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WORKERS' COMPENSATION TREATMENT GUIDELINES
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Chapter DWD 81 is created to read:

CHAPTER DWD 81

WORKER'S COMPENSATION TREATMENT GUIDELINES

DWD 81.01 Purpose and application. (1) PURPOSE. The purpose of this section is to establish guidelines for necessary treatment of employees with compensable worker's compensation injuries to prevent unnecessary treatment under s. 102.16 (2m), Stats. Sections DWD 81.01 to 81.13 do not affect any determination of liability for an injury under ch.102, Stats. and are not intended to expand or restrict a health care provider's scope of practice under any other statute.

(2) APPLICATION. All treatment must be medically necessary as defined in s. DWD 81.03 (10). In the absence of a specific guideline, any applicable general guidelines govern. A departure from a guideline that limits the duration or type of treatment may be appropriate in any one of the circumstances specified in s. DWD 81.04 (5). All limitations on the duration of a specific treatment modality or type of modality begin with the first time the modality is initiated after (Insert effective date). Sections DWD 81.01

to 81.13 do not apply to treatment of an injury after an insurer has denied liability for the injury. However, in such cases the guidelines apply to treatment initiated after liability has been established. References to days and weeks in ss. DWD 81.04 to 81.13 mean calendar days and weeks unless specified otherwise.

DWD 81.02 Incorporation by reference. The ICD-9-CM diagnostic codes referenced in ss. DWD 81.01 to 81.12 are contained in the fourth edition of the International Classification of Diseases, Clinical Modification, 9th Revision, 1994, and corresponding annual updates. This document is subject to annual revisions and is incorporated by reference. It is published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, and may be purchased through the Superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402.

DWD 81.03 Definitions. (1) SCOPE. The terms used in ss. DWD 81.01 to 81.13 have the meanings given them in this section.

(2) "Active treatment" means treatment specified in ss. DWD81.06 (4); DWD 81.07 (4);DWD 81.08 (4);DWD 81.09 (4) and DWD 81.10 (2) which requires active patient participation in a therapeutic program to increase flexibility, strength, endurance or awareness of proper body mechanics.

(3) "Chronic pain syndrome" means any of the following set of verbal or nonverbal behaviors that:

(a) Involve the complaint of enduring pain.

(b) Differ significantly from the patient's preinjury behavior.

(c) Have not responded to previous appropriate treatment.

(d) Are not consistent with a known organic syndrome which has remained untreated.

(e) Interfere with physical, psychological, social or vocational functioning.

(4) CONDITION. A patient's "condition" means the symptoms, physical signs, clinical findings and functional status that characterize the complaint, illness, or injury related to a current claim for compensation.

(5) "Emergency treatment" means treatment that is required for the immediate diagnosis and treatment of a medical condition that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death, or immediately necessary to alleviate severe pain .Emergency

treatment includes treatment delivered in response to symptoms that may or may not represent an actual emergency but that is necessary to determine whether an emergency exists.

(6) "Etiology" means the anatomic alteration, physiologic dysfunction or other biological or psychological abnormality which is considered a cause of the patient's condition.

(7) "Functional status" means the ability of an individual to engage in activities of daily living and other social, recreational and vocational activities.

(8) "Initial nonsurgical management or treatment" is initial treatment provided after an injury that includes passive treatment, active treatment, injections and durable medical equipment under ss. DWD 81.06 (3) to (5) and (8); DWD 81.07 (3) to (5) and (8); DWD 81.08 (3) to (5) and (8) ; DWD 81.09 (3) to (5) and (8); and DWD 81.10 (2). Scheduled and nonscheduled medication may be a part of initial nonsurgical treatment. Initial nonsurgical management does not include surgery or chronic management modalities under s. DWD 81.13

(9) "Medical imaging procedure" is a technique, process or technology used to create a visual image of the body or its function. Medical imaging includes, but is not limited to: X-rays, tomography, angiography, venography, myelography, computed tomography (CT) scanning, magnetic resonance imaging (MRI) scanning, ultrasound imaging, nuclear isotope imaging, PET scanning, and thermography.

(10) "Medically necessary treatment" means those health services for a compensable injury that are reasonable and necessary for the diagnosis and to cure and relieve a condition consistent with any applicable treatment guidelines in ss. DWD 81.04 to 81.13. Where ss. DWD 81.04 to 81.13 do not apply, the treatment must be reasonable and necessary for the diagnosis and to cure and relieve a condition consistent with the current accepted standards of practice within the scope of the provider's license or certification.

(11) "Neurologic deficit" means a loss of function secondary to involvement of the central or peripheral nervous system. This may include, but is not limited to, motor loss; spasticity; loss of reflex; radicular or anatomic sensory loss; loss of bowel, bladder or erectile function; impairment of special senses, including vision, hearing, taste, or smell; or deficits in cognitive or memory function.

(12) "Static neurologic deficit" means any neurologic deficit that has remained the same by history or noted by repeated examination since onset.

(13) "Progressive neurologic deficit" means any neurologic deficit that has become worse by history or noted by repeated examination since onset.

(14) "Passive treatment" is any treatment modality specified in ss. DWD 81.06 (3); DWD 81.07 (3); DWD 81.08 (3); DWD 81.09 (3) and DWD 81.10 (2). Passive treatment modalities include bedrest; thermal treatment; traction; acupuncture; electrical muscle stimulation; braces; manual and mechanical therapy; massage; and adjustments.

(15) "Therapeutic injection" is any injection modality specified in ss. DWD 81.06 (5); DWD 81.07 (5); DWD 81.08 (5);DWD 81.09 (5) and DWD 81.10 (2) Therapeutic injections include trigger point injections, sacroiliac injections, facet joint injections, facet nerve blocks, nerve root blocks, epidural injections, soft tissue injections, peripheral nerve blocks, injections for peripheral nerve entrapment, and sympathetic blocks.

DWD 81.04 General treatment guidelines; excessive treatment.(1) GENERAL. (a) All treatment must be medically necessary treatment, as defined in s. DWD 81.03 (10). The health care provider must evaluate the medical necessity of all treatment under par. (b) on an ongoing basis. Sections DWD 81.03 to 81.13 do not require or permit any more frequent examinations than would normally be required for the condition being treated, but do require ongoing evaluation of the patient that is medically necessary and consistent with accepted medical practice.

(b) The health care provider must evaluate at each visit whether initial nonsurgical treatment for the low back, cervical, thoracic and upper extremity conditions specified in ss. DWD 81.06 to 81. 09 is effective according to subds. 1 to 3. No later than any applicable treatment response time in ss. DWD 81.06 to 81.09, the health care provider must evaluate whether the passive, active, injection or medication treatment modality is resulting in progressive improvement as specified in all of the following:

1. The employee's subjective complaints of pain or disability are progressively improving, as evidenced by documentation in the medical record of decreased distribution, frequency or intensity of symptoms.

2. The objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury.

3. The employee's functional status, especially vocational activities, is progressively improving, as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive limitations on activity.

(c) Except as otherwise provided under ss. DWD 81.06 (3)(b); DWD 81.07(3)(b); DWD 81.08(3)(b) and DWD 81.09(3)(b) if there is not progressive improvement in at least two criteria of par. (b) 1 to 3, the modality must be discontinued or significantly modified, or the provider must reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality can be delegated to an allied health professional directly providing the treatment.

(d) The health care provider must use the least intensive setting appropriate and must assist the employee in becoming independent in the employee's own care to the extent possible so that prolonged or repeated use of health care providers and medical facilities is minimized.

(2) DOCUMENTATION. A health care provider must maintain an appropriate record of any treatment provided to a patient. An appropriate record is a legible health care service record or report that substantiates the nature and necessity of a health care service being billed and its relationship to the work injury.

(3) NONOPERATIVE TREATMENT. Health care providers shall provide a trial of nonoperative treatment before offering or performing surgical treatment unless the treatment for the condition requires immediate surgery, unless an emergency situation exists, or unless the accepted standard of initial treatment for the condition is surgery.

(4) CHEMICAL DEPENDENCY. The health care provider shall maintain diligence to detect incipient or actual chemical dependency to any medication prescribed for treatment of the employee's condition. In cases of incipient or actual dependency, the health care provider shall refer the employee for appropriate evaluation and treatment of the dependency.

(5) DEPARTURE FROM GUIDELINES. A departure from a guideline that limits the duration or type of treatment in ss. DWD 81.03 to 81.13 may be appropriate in any of the following circumstances:

(a) Where there is a documented medical complication.

(b) Where previous treatment did not meet the accepted standard of practice and meet the guidelines of ss. DWD 81.03 to 81.13 for the health care provider who ordered the treatment.

(c) Where the treatment is necessary to assist the employee in the initial return to work where the employee's work activities place stress on the part of the body affected by the work injury. The health care provider must document in the medical record the specific work activities that place stress on the affected body part, the details of the treatment plan and treatment delivered on each visit, the employee's response to the treatment, and efforts to promote employee independence in the employee's own care to the extent possible so that prolonged or repeated use of health care providers and medical facilities is minimized.

(d) Where the treatment continues to meet two of the following three criteria, as documented in the medical record:

1. The employee's subjective complaints of pain are progressively improving as evidenced by documentation in the medical record of decreased distribution, frequency or intensity of symptoms.

2. The employee's objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury; and

3. The employee's functional status, especially vocational activity, is objectively improving as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive limitations on activity.

(e) Where there is an incapacitating exacerbation of the employee's condition. However, additional treatment for the incapacitating exacerbation may not exceed, and must comply with the guidelines in ss. DWD 81.03 to 81.13.

DWD 81.05 Guidelines for medical imaging. (1) GENERAL PRINCIPLES. All medical imaging must comply with all categories specified in pars. (a) to (e). Except for emergency evaluation of significant trauma, a health care provider must document in the medical record an appropriate history and physical examination, along with a review of any existing medical records and laboratory or imaging studies regarding the patient's condition before ordering any imaging study.

(a) *Effective imaging*. A health care provider should initially order the single most effective imaging study for diagnosing the suspected etiology of a patient's condition. No concurrent or additional imaging studies should be ordered until the results of the first study are known and reviewed by the treating

health care provider. If the first imaging study is negative, no additional imaging is indicated except for repeat and alternative imaging allowed under pars. (d) and (e).

(b) *Appropriate imaging*. Imaging solely to rule out a diagnosis not seriously being considered as the etiology of the patient's condition is not indicated.

(c) *Routine imaging*. Imaging on a routine basis is not indicated unless the information from the study is necessary to develop a treatment plan.

(d) *Repeat imaging*. Repeat imaging of the same views of the same body part with the same imaging modality is not indicated except for any of the following:

1. To diagnose a suspected fracture or suspected dislocation.

2. To monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment; repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment.

3. To follow up a surgical procedure.

4. To diagnose a change in the patient's condition marked by new or altered physical findings.

5. To evaluate a new episode of injury or exacerbation which in itself would warrant an imaging study.

6. When the treating health care provider and a radiologist from a different practice have reviewed a previous imaging study and agree that it is a technically inadequate study.

(e) *Alternative imaging*. 1 Persistence of a patient's subjective complaint or failure of the condition to respond to treatment are not legitimate indications for repeat imaging. In this instance an alternative imaging study may be indicated if another etiology of the patient's condition is suspected because of the failure of the condition to improve.

2. Alternative imaging is not allowed to follow up negative findings unless there has been a change in the suspected etiology and the first imaging study is not an appropriate evaluation for the suspected etiology.

3. Alternative imaging is allowed to follow up abnormal but inconclusive findings in another imaging study. An inconclusive finding is one that does not provide an adequate basis for accurate diagnosis.

(2) SPECIFIC IMAGING PROCEDURES FOR LOW BACK PAIN. Except for the emergency evaluation of significant trauma, a health care provider must document in the medical record an appropriate history and physical examination, along with a review of any existing medical records and laboratory or imaging studies regarding the patient's condition, before ordering any imaging study of the low back.

(a) Computed tomography (CT) scanning is indicated any time that one of the following conditions is met:

1. When cauda equina syndrome is suspected.

2. For evaluation of progressive neurologic deficit.

3. When bony lesion is suspected on the basis of other tests or imaging procedures.

(b) Except as specified in par. (a) CT scanning is not indicated in the first eight weeks after an injury. Computed tomography scanning is indicated after eight weeks if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities.

(c) Magnetic resonance imaging (MRI) scanning is indicated any time that one of the following conditions is met:

1. When cauda equina syndrome is suspected.

2. For evaluation of progressive neurologic deficit.

3. When previous spinal surgery has been performed and there is a need to differentiate scar due to previous surgery from disc herniation, tumor or hemorrhage.

4. Suspected discitis.

(d) Except as specified in par. (c), MRI scanning is not indicated in the first eight weeks after an injury. Magnetic resonance imaging scanning is indicated after eight weeks if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities.

(e) Myelography is indicated in any of the following circumstances:

1. May be substituted for otherwise indicated CT scanning or MRI scanning in accordance with pars. (a) and (c), if those imaging modalities are not locally available.

2. In addition to CT scanning or MRI scanning, if there are progressive neurologic deficits or changes and CT scanning or MRI scanning has been negative.

3. For preoperative evaluation in cases of surgical intervention, but only if CT scanning or MRI scanning have failed to provide a definite preoperative diagnosis.

(f) Computed tomography myelography is indicated in any of the following circumstances:

1. The patient's condition is predominantly sciatica, and there has been previous spinal surgery, and tumor is suspected.

2. The patient's condition is predominantly sciatica and there has been previous spinal surgery and MRI scanning is equivocal.

3. When spinal stenosis is suspected and the CT or MRI scanning is equivocal.

4. In addition to CT scanning or MRI scanning, if there are progressive neurologic symptoms or changes and CT scanning or MRI scanning has been negative.

5. For preoperative evaluation in cases of surgical intervention, but only if CT scanning or MRI scanning have failed to provide a definite preoperative diagnosis.

(g) Intravenous enhanced CT scanning is indicated only if there has been previous spinal surgery, and the imaging study is being used to differentiate scar due to previous surgery from disc herniation or tumor, but only if intrathecal contrast for CT-myelography is contraindicated and MRI scanning is not available or is also contraindicated.

(h) Gadolinium enhanced MRI scanning is indicated in any of the following:

1. There has been previous spinal surgery, and the imaging study is being used to differentiate scar due to previous surgery from disc herniation or tumor.

2. Hemorrhage is suspected.

3. Tumor or vascular malformation is suspected.

4. Infection or inflammatory disease is suspected.

5. Unenhanced MRI scanning was equivocal.

(i) Discography is indicated when:

1. All of the following are present.

a. Back pain is the predominant complaint.

b. The patient has failed to improve with initial nonsurgical management.

c. Other imaging has not established a diagnosis.

d. Lumbar fusion surgery is being considered as a therapy.

2. There has been previous spinal surgery, and pseudoarthrosis, recurrent disc herniation, annular tear or internal disc disruption is suspected.

(j) Computed tomography discography is indicated when any of the following is present:

1. Sciatica is the predominant complaint and lateral disc herniation is suspected.

2. If appropriately performed discography is equivocal or paradoxical, with a normal X-ray pattern but a positive pain response, and an annular tear or intra-annular injection is suspected.

(k) Nuclear isotope imaging ,including technicium, indium, and gallium scans, are not indicated unless tumor, stress fracture, infection, avascular necrosis or inflammatory lesion is suspected on the basis of history, physical examination findings, laboratory studies or the results of other imaging studies.

(L) Thermography is not indicated for the diagnosis of any of the clinical categories of low back conditions in s. DWD 81.06 (1) (a).

(m) Anterior-posterior (AP) and lateral X-rays of the lumbosacral spine are limited by subds. 1 and 2.

1. Anterior-posterior (AP) and lateral X-rays of the lumbosacral spine are indicated in any of the following circumstances:

a. When there is a history of significant acute trauma as the precipitating event of the patient's condition, and fracture, dislocation or fracture dislocation is suspected.

b. When the history, signs, symptoms or laboratory studies indicate possible tumor, infection or inflammatory lesion.

c. For postoperative follow-up of lumbar fusion surgery.

d. When the patient is more than 50 years of age.

e. Before beginning a course of treatment with spinal adjustment or manipulation.

f. Eight weeks after an injury if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities.

2. Anterior-posterior (AP) and lateral X-rays of the lumbosacral spine are not indicated in the following circumstances:

a. To verify progress during initial nonsurgical treatment.

b. To evaluate a successful initial nonsurgical treatment program.

(n) Oblique X-rays of the lumbosacral spine are limited in subds. 1 and 2.

1. Oblique X-rays of the lumbosacral spine are indicated in any of the following circumstances:

a. To follow up abnormalities detected on anterior-posterior or lateral X-ray.

b. For postoperative follow-up of lumbar fusion surgery.

c. To follow up spondylolysis or spondylolisthesis not adequately diagnosed by other indicated imaging procedures.

2. Oblique X-rays of the lumbosacral spine are not indicated as part of a package of X-rays including anterior-posterior and lateral X-rays of the lumbosacral spine.

(o) Electronic X-ray analysis of plain radiographs and diagnostic ultrasound of the lumbar spine are not indicated for diagnosis of any of the low back conditions in s. DWD 81.06 (1) (a).

DWD 81.06 Low back pain. (1) DIAGNOSTIC PROCEDURES FOR TREATMENT OF LOW BACK PAIN. (a) A health care provider shall determine the nature of the condition before initiating treatment.

(b) An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the health care provider must assign the patient at each visit to the appropriate clinical category according to subds. 1 to 4. The diagnosis must be documented in the medical record. For the purposes of subds. 2 and 3 , "radicular pain" means pain radiating distal to the knee, or pain conforming to a dermatomal distribution and accompanied by anatomically congruent motor weakness or reflex changes. This subsection does not apply to fractures of the lumbar spine, or back pain due to an infectious, immunologic, metabolic, endocrine, neurologic, visceral, or neoplastic disease process.

1. Regional low back pain, includes referred pain to the leg above the knee unless it conforms to an L2, L3, or L4 dermatomal distribution and is accompanied by anatomically congruent motor weakness or reflex changes. Regional low back pain includes the diagnoses of lumbar, lumbosacral, or sacroiliac: strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury, spondylosis and other

diagnoses for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the lumbar spine or sacroiliac joints and which effects the lumbosacral region, with or without referral to the buttocks and/or leg above the knee, including, but not limited to, ICD-9-CM codes 720 to 720.9, 721, 721.3, 721.5 to 721.90, 722, 722.3, 722.32, 722.5, 722.51, 722.52, 722.6, 722.9, 722.90, 722.93, 724.2, 724.5, 724.6, 724.8, 724.9, 732.0, 737 to 737.9, 738.4, 738.5, 739.2 to 739.4, 756.1 to 756.19, 847.2 to 847.9, 922.3, 926.1, 926.11, and 926.12.

2. Radicular pain, with or without regional low back pain, with static or no neurologic deficit. This includes the diagnoses of sciatica; lumbar or lumbosacral radiculopathy, radiculitis or neuritis; displacement or herniation of intervertebral disc with myelopathy, radiculopathy, radiculitis or neuritis; spinal stenosis with myelopathy, radiculopathy, radiculitis or neuritis; and any other diagnoses for pain in the leg below the knee believed to originate with irritation of a nerve root in the lumbar spine, including, but not limited to, the ICD-9-CM codes 721.4, 721.42 721.91, 722.1, 722.10, 722.2, 722.7, 722.73, 724.0, 724.00, 724.02, 724.09, 724.3, 724.4, and 724.9. In these cases, neurologic findings on history and physical examination are either absent or do not show progressive deterioration.

3. Radicular pain, with or without regional low back pain, with progressive neurologic deficit. This includes the same diagnoses as subd. 2 , however, this category applies when there is a history of progressive deterioration in the neurologic symptoms and physical findings which include worsening sensory loss, increasing muscle weakness or progressive reflex changes.

4. Cauda equina syndrome, which is a syndrome characterized by anesthesia in the buttocks, genitalia or thigh and accompanied by disturbed bowel and bladder function, ICD-9-CM codes 344.6, 344.60, and 344.61.

(c) Laboratory tests are not indicated in the evaluation of a patient with regional low back pain, radicular pain or cauda equina syndrome, except in any of the following circumstances:

1. When a patient's history, age or examination suggests infection, metabolic-endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders, such as rheumatoid arthritis or ankylosing spondylitis.

2. To evaluate potential adverse side effects of medications.

3. As part of a preoperative evaluation.

(d) Laboratory tests may be ordered at any time the health care provider suspects any of these conditions, but the health care provider must justify the need for the tests ordered with clear documentation of the indications.

(e) Medical imaging evaluation of the lumbosacral spine must be based on the findings of the history and physical examination and cannot be ordered before the health care provider's clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and must comply with all of the standards in s. DWD 81.05 (1) and (2). The health care provider must document the appropriate indications for any medical imaging studies obtained.

(f) EMG and nerve conduction studies are always inappropriate for regional low back pain as defined in s. DWD 81.06 (1) (b) 1. EMG and nerve conduction studies may be an appropriate diagnostic tool for radicular pain and cauda equina syndrome as defined in s. DWD 81.06 (1) (b) 2 to 4 after the first three weeks of radicular symptoms. Repeat EMG and nerve conduction studies for radicular pain and cauda equina syndrome are not indicated unless a new neurologic symptom or finding has developed which in itself would warrant electrodiagnostic testing. Failure to improve with treatment is not an indication for repeat testing.

(g) The use of any of the following procedures or tests is not indicated for the diagnosis of any of the clinical categories in par. (b):

1. Surface electromyography or surface paraspinal electromyography.

2. Thermography.

3. Plethysmography.

4. Electronic X-ray analysis of plain radiographs.

5. Diagnostic ultrasound of the lumbar spine.

6. Somatosensory evoked potentials (SSEP) and motor evoked potentials (MEP).

(h) Computerized range of motion or strength measuring tests are not indicated during the period of initial nonsurgical management, but may be indicated during the period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. During the period of initial nonsurgical management, computerized range of motion or strength

testing may be performed but must be done in conjunction with an office visit with a practitioner's evaluation or treatment, or physical or occupational therapy evaluation or treatment.

(i) Personality or psychosocial evaluations may be indicated for evaluating patients who continue to have problems despite appropriate care. The treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, the health care provider performing the evaluation must consider all of the following:

1. Is symptom magnification occurring?

2. Does the patient exhibit an emotional reaction to the injury, such as depression, fear or anger which is interfering with recovery?

3. Are there other personality factors or disorders which are interfering with recovery?

4. Is the patient chemically dependent?

5. Are there any interpersonal conflicts interfering with recovery?

6. Does the patient have a chronic pain syndrome or psychogenic pain?

7. In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?

(j) Guidelines for diagnostic analgesic blocks or injection studies include facet joint injection, facet nerve injection, epidural differential spinal block, nerve block and nerve root block.

1. These procedures are used to localize the source of pain before surgery and to diagnose conditions which fail to respond to initial nonsurgical management.

2. These injections are invasive and when done as diagnostic procedures only, are not indicated unless noninvasive procedures have failed to establish the diagnosis.

3. Selection of patients, choice of procedure and localization of the level of injection should be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms.

4. These blocks and injections can also be used as therapeutic modalities and as such are subject to the guidelines of sub. (5).

(k) Functional capacity assessment or evaluation is a comprehensive and objective assessment of a patient's ability to perform work tasks. The components of a functional capacity assessment or evaluation include, but are not limited to, neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility and measurement of postural tolerance. A functional capacity assessment or evaluation is an individualized testing process and the component tests and measurements are determined by the patient's condition and the requested information. Functional capacity assessments and evaluations are performed to determine and report a patient's physical capacities in general or to determine work tolerance for a specific job, task or work activity.

1. Functional capacity assessment or evaluation is not indicated during the period of initial nonsurgical management.

2. After the period of initial nonsurgical management functional capacity assessment or evaluation is indicated in either of the following circumstances:

a. Activity restrictions and capabilities must be identified.

b. There is a question about the patient's ability to do a specific job.

3. A functional capacity evaluation is not appropriate to establish baseline performance before treatment, or for subsequent assessments, to evaluate change during or after treatment.

4. Only one completed functional capacity evaluation is indicated per injury.

(L) Consultations with other health care providers can be initiated at any time by the treating health care provider consistent with accepted medical practice.

(2) GENERAL TREATMENT GUIDELINES FOR LOW BACK PAIN. (a) All medical care for low back pain, appropriately assigned to a clinical category in sub. (1) is determined by the clinical category to which the patient has been assigned. General guidelines for treatment modalities are set forth in subs. (3) to (10). Specific treatment guidelines for each clinical category are set forth in subs. (11) to (13), as follows:

1. Subsection (11) governs regional low back pain.

2. Subsection (12) governs radicular pain with no or static neurologic deficits.

3. Subsection (13) governs cauda equina syndrome and radicular pain with progressive neurologic deficits.

(b) The health care provider must, at each visit, reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing and opinions and information obtained from consultations with other health care providers. When the clinical category is changed, the treatment plan must be appropriately modified to reflect the new clinical category. However, a change of clinical category does not in itself allow the health care provider to continue a therapy or treatment modality past the maximum duration specified in subs. (3) to (10), or to repeat a therapy or treatment previously provided for the same injury.

(c) In general, a course of treatment is divided into three phases.

1. First, all patients with low back problems, except patients with progressive neurologic deficit or cauda equina syndrome under sub. (1) (b) 3 and 4, must be given initial nonsurgical management which may include active treatment modalities, passive treatment modalities, injections, durable medical equipment, and medications. These modalities and guidelines are described in subs. (3) to (5), (8) and (10). The period of initial nonsurgical treatment begins with the first active, passive, medication, durable medical equipment or injection modality initiated. Initial nonsurgical treatment must result in progressive improvement as specified in sub. (9).

2. Second, for patients with persistent symptoms, initial nonsurgical management is followed by a period of surgical evaluation. This evaluation should be completed in a timely manner. Surgery, if indicated, should be performed as expeditiously as possible consistent with sound medical practice and subs. (6), (11) and (13) and s. DWD 81.12. The treating health care provider may do the evaluation or may refer the employee to another practitioner.

a. Patients with radicular pain with progressive neurological deficit or cauda equina syndrome may require immediate surgical therapy.

b. Any patient who has had surgery may require postoperative therapy in a clinical setting with active and passive treatment modalities. This therapy may be in addition to any received during the period of initial nonsurgical care.

c. Surgery must follow the guidelines in subs. (6), (11), (13) and s. DWD 81.12.

d. A decision against surgery at this time does not preclude a decision for surgery made at a later date.

3. Third, for those patients who are not candidates for or refuse surgical therapy, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be indicated. Chronic management modalities are described in s. DWD 81.13, and may include durable medical equipment as described in sub. (8).

(d) A treating health care provider may refer the employee for a consultation at any time during the course of treatment consistent with accepted medical practice.

(3). PASSIVE TREATMENT MODALITIES. (a) Except as set forth in par. (b) and s. DWD 81.04 (5), the use of passive treatment modalities in a clinical setting as set forth in pars. (c) to (i) is not indicated beyond 12 calendar weeks after any of the passive modalities in pars. (c) to (i) are initiated. There are no limitations on the use of passive treatment modalities by the employee at home.

(b) An additional 12 visits for the use of passive treatment modalities over an additional 12 months may be provided if all of the following apply:

1. The employee is released to work or is permanently totally disabled and the additional passive treatment must result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care.

2. The treatment must not be given on a regularly scheduled basis.

3. The health care provider must document in the medical record a plan to encourage the employee's independence and decreased reliance on health care providers.

4. Management of the employee's condition must include active treatment modalities during this period.

5. The additional 12 visits for passive treatment must not delay the required surgical or chronic pain evaluation required by this chapter.

6. Passive care is inappropriate while the employee has chronic pain syndrome.

(c) Guidelines for adjustment or manipulation of joints that includes chiropractic and osteopathic adjustments or manipulations include the following:

1. Time for treatment response is three to five treatments.

2. Maximum treatment frequency is up to five times per week for the first one to two weeks decreasing in frequency thereafter.

3. Maximum treatment duration is 12 weeks.

(d) Thermal treatment includes all superficial and deep heating and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool and fluidotherapy. Deep thermal modalities include diathermy, ultrasound and microwave.

1. Guidelines for thermal treatment given in a clinical setting include the following:

a. Time for treatment response is two to four treatments.

b. Maximum treatment frequency is up to five times per week for the first one to three weeks decreasing in frequency thereafter.

c. Maximum treatment duration is 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

2. Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs and cold soaks which can be applied by the patient without health care provider assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.

(e) Electrical muscle stimulation includes galvanic stimulation, TENS, interferential and microcurrent techniques.

1. Guidelines for electrical muscle stimulation given in a clinical setting include the following:

a. Time for treatment response is two to four treatments.

b. Maximum treatment frequency is up to five times per week for the first one to three weeks decreasing in frequency thereafter.

c. Maximum treatment duration is 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

2. Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device must be in a supervised setting in order to ensure proper electrode placement and patient education. Treatment guidelines include the following:

a. The time for patient education and training is one to three sessions.

b. Patient may use the electrical stimulation device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

(f) Treatment guidelines for mechanical traction include the following:

a. Treatment given in a clinical setting.

1. Time for treatment response is three treatments.

2. Maximum treatment frequency is up to three times per week for the first one to three weeks decreasing in frequency thereafter.

3. Maximum treatment duration is 12 weeks in a clinical setting but only if used in conjunction with other therapies.

b. Home use of a mechanical traction device may be prescribed as follow-up to use of traction in a clinical setting if it has proven to be effective treatment and is expected to continue to be effective treatment. Initial use of a mechanical traction device must be in a supervised setting in order to ensure proper patient education. Treatment guidelines for home use include the following:

1. Time for patient education and training is one session.

2. Patient may use the mechanical traction device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

(g) Guidelines for acupuncture treatments. Endorphin-mediated analgesic therapy includes classic acupuncture and acupressure. Treatment guidelines include the following:

1. Time for treatment response is three to five sessions.

2. Maximum treatment frequency is up to three times per week for one to three weeks decreasing in frequency thereafter.

3. Maximum treatment duration is 12 weeks.

(h) Manual therapy includes soft tissue and joint mobilization, therapeutic massage and manual traction. Treatment guidelines for manual therapy include the following:

1. Time for treatment response is three to five treatments.

2. Maximum treatment frequency is up to five times per week for the first one to two weeks decreasing in frequency thereafter.

3. Maximum treatment duration is 12 weeks.

(i) Phoresis includes iontophoresis and phonophoresis. Treatment guidelines for phoresis include the following:

1. Time for treatment response is three to five sessions.

2. Maximum treatment frequency is up to three times per week for the first one to three weeks decreasing in frequency thereafter.

3. Maximum treatment is nine sessions of either iontophoresis or phonophoresis, or combination, to any one site, with a maximum duration of 12 weeks for all treatment.

(j) Bedrest. Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Bedrest should not be prescribed for more than seven days.

(k) Treatment guidelines for spinal braces and other movement-restricting appliances include the following:

1. Bracing required for longer than two weeks must be accompanied by active muscle strengthening exercise to avoid deconditioning and prolonged disability.

2. Time for treatment response is three days.

3. Treatment frequency is limited to intermittent use during times of increased physical stress or prophylactic use at work.

4. Maximum continuous duration is three weeks unless patient is status postfusion.

(4) ACTIVE TREATMENT MODALITIES. (a) Active treatment modalities must be used as set forth in subds. 1 to 4 Use of active treatment modalities can extend past the 12-week limitation on passive treatment modalities so long as the maximum duration for the active modality is not exceeded.

1. Education must teach the patient about pertinent anatomy and physiology as it relates to spinal function for the purpose of injury prevention. Education includes training on posture, biomechanics and relaxation. The maximum number of treatments is three visits, which includes an initial education and training session, and two follow-up visits.

2. Posture and work method training must instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, neck and arms, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, exercises and simulated work tasks. The maximum number of treatments is three visits.

3. Worksite analysis and modification must examine the patient's work station, tools and job duties. Recommendations are made for the alteration of the work station, selection of alternate tools, modification of job duties, and provision of adaptive equipment. The maximum number of treatments is three visits.

4. Exercise, which is important to the success of an initial nonsurgical treatment program and a return to normal activity, must include active patient participation in activities designed to increase flexibility, strength, endurance or muscle relaxation. Exercise must, at least in part, be specifically aimed at the musculature of the lumbosacral spine. While aerobic exercise and extremity strengthening may be performed as adjunctive treatment, this shall not be the primary focus of the exercise program.

(b) Exercises must be evaluated to determine if the desired goals are being attained. Strength, flexibility, and endurance must be objectively measured. The health care provider may objectively measure the treatment response as often as necessary for optimal care after the initial evaluation.

(c) Subds. 1 and 2 govern supervised and unsupervised exercise, except for computerized exercise programs and health clubs, which are governed by s. DWD 81.13.

1.’ Supervised exercise.’ One goal of an exercise program must be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition must be promoted. Treatment guidelines for supervised exercise includes the following:

a. Maximum treatment frequency is three times per week for three weeks, and should decrease in frequency thereafter.

b. Maximum duration is 12 weeks.

2. Unsupervised exercise must be provided in the least intensive setting appropriate to the goals of the exercise program, and may supplement or follow the period of supervised exercise. Treatment guidelines for unsupervised exercise include the following:

a. Maximum treatment frequency is up to three visits for instruction and monitoring.

b. There is no limit on the duration or frequency of exercise at home.

(5) THERAPEUTIC INJECTIONS. Injection modalities are indicated as set forth in pars. (a) to (c) Use of injections can extend past the 12-week limit on passive treatment modalities so long as the maximum treatment for injections is not exceeded.

(a) Therapeutic injections, including injections of trigger points, facet joints, facet nerves, sacroiliac joints, sympathetic nerves, epidurals, nerve roots and peripheral nerves. Therapeutic injections can only be given in conjunction with active treatment modalities directed to the same anatomical site.

1. Treatment guidelines for trigger point injections include the following:

a. Time for treatment response is within 30 minutes.

b. Maximum treatment frequency is once per week to any one site if a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then trigger point injections should be redirected to other areas or discontinued. No more than three injections to different sites per patient visit.

c. Maximum treatment is four injections to any one site.

2. Treatment guidelines for sacroiliac joint injections include the following:

a. Time for treatment response is within one week.

b. Maximum treatment frequency, can repeat injection two weeks after the previous injection if a positive response to the first injection. Only two injections per patient visit.

c. Maximum treatment is two injections to any one site.

3. Treatment guidelines for facet joint or nerve injections include the following:

a. Time for treatment response is within one week.

b. Maximum treatment frequency is once every two weeks to any one site if a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections should be discontinued. No more than three injections to different sites per patient visit.

c. Maximum treatment is three injections to any one site.

4. Treatment guidelines for nerve root blocks include the following:

a. Time for treatment response is within one week.

b. Maximum treatment frequency, can repeat injection two weeks after the previous injection if a positive response to the first injection. Only three injections to different sites per patient visit.

c. Maximum treatment is two injections to any one site.

5. Treatment guidelines for epidural injections include the following:

a. Time for treatment response is within one week.

b. Maximum treatment frequency, once every two weeks if a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections should be discontinued. Only one injection per patient visit.

c. Maximum treatment is three injections.

(b) Permanent lytic or sclerosing injections, including radio frequency denervation of the facet joints. These injections can only be given in conjunction with active treatment modalities directed to the same anatomical site. Treatment guidelines include the following:

a. Time for treatment response is within one week.

b. Maximum treatment frequency, may repeat once for any site.

c. Maximum duration is two injections to any one site.

(c) Prolotherapy and botulinum toxin injections are not indicated in the treatment of low back problems.

(6) SURGERY, INCLUDING DECOMPRESSION PROCEDURES AND ARTHRODESIS. (a) Surgery may only be performed if it also meets the specific guidelines specified in subs. (11) to (13) and s. DWD 81.12.

(b) In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities may be provided, even if these modalities had been used in the preoperative treatment of the condition. In the postoperative period the maximum treatment duration with passive treatment modalities in a clinical setting from the initiation of the first passive modality used, except bedrest or bracing, is as follows:

1. Eight weeks following lumbar decompression or implantation of a dorsal column stimulator or morphine pump.

2. 12 weeks following arthrodesis.

(c) Repeat surgery must also meet the guidelines of subs. (11) to (13) and s. DWD 81.12

(d) The following surgical therapies have very limited application, must be within the guidelines listed, and a personality or psychosocial evaluation that indicates that the patient is likely to benefit from the treatment.

1. Dorsal column stimulator is indicated for a patient who has neuropathic pain, and is not a candidate for any other surgical therapy, and has had a favorable response to a trial screening period.

2. Morphine pump is indicated for a patient who has somatic pain, and is not a candidate for any other surgical therapy, and has had a favorable response to a trial screening period.

(7) CHRONIC MANAGEMENT. Chronic management of low back pain must be provided according to the guidelines of s. DWD 81.13.

(8) DURBLE MEDICAL EQUIPMENT. Durable medical equipment is indicated in any of the following:

(a) Lumbar braces, corsets or supports are indicated as specified in sub. (3) (k).

(b) For patients using electrical stimulation or mechanical traction devices at home, the device and any required supplies are indicated within the guidelines of sub. (3) (e) and (f).

(c) Exercise equipment for home use, including bicycles, treadmills and stairclimbers, are indicated only within the context of a program or plan of an approved chronic management program. This equipment is not indicated during initial nonsurgical care or during reevaluation and surgical therapy. If the employer has an appropriate exercise facility on its premises with the prescribed equipment, the insurer may mandate use of that facility instead of authorizing purchase of the equipment for home use.

1.' Indications'. The patient is deconditioned and requires reconditioning which can be accomplished only with the use of the prescribed exercise equipment. The health care provider must document specific reasons why the exercise equipment is necessary and cannot be replaced with other activities.

2.' Requirements'. The use of the equipment must have specific goals and there must be a specific set of prescribed activities.

(d) Any of the the following durable medical equipment is not indicated for home use for low back conditions:

1. Whirlpools, Jacuzzis, hot tubs and special bath or shower attachments.

2. Beds, waterbeds, mattresses, chairs, recliners and loungers.

(9) EVALUATION OF TREATMENT BY HEALTH CARE PROVIDER. (a) The health care provider must evaluate at each visit whether the treatment is medically necessary, and must evaluate whether initial nonsurgical treatment is effective according to pars. (b) to (d) No later than the time for treatment response established for the specific modality as specified in subs. (3) to (5), the health care provider must evaluate whether the passive, active, injection or medication treatment modality is resulting in progressive improvement as specified in pars. (b) to (d).

(b) The employee's subjective complaints of pain or disability are progressively improving, as evidenced by documentation in the medical record of decreased distribution, frequency or intensity of symptoms.

(c) The objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of the injury.

(d) The employee's functional status, especially vocational activity, is progressively improving, as evidenced by documentation in the medical record or successive reports of work ability, of less restrictive imitations on activity.

(e) If there is not progressive improvement in at least two criteria specified in pars. (b) to (d), the modality must be discontinued or significantly modified or the provider must reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality can be delegated to an allied health care provider directly providing the treatment.

(10) SCHEDULED AND NONSCHEDULED MEDICATION. (a) Prescription of controlled substance medications under ch. 450, Stats., including without limitation, narcotics, is indicated only for the treatment of severe acute pain. These medications are not indicated in the treatment of patients with regional low back pain after the first two weeks.

(b) Patients with radicular pain may require longer periods of treatment.

(c) The health care provider must document the rationale for the use of any scheduled medication. Treatment with nonscheduled medication may be appropriate during any phase of treatment and

intermittently after all other treatment has been discontinued. The prescribing health care provider must determine that ongoing medication is effective treatment for the patient's condition.

(11) SPECIFIC TREATMENT GUIDELINES FOR REGIONAL LOW BACK PAIN. (a) Initial nonsurgical treatment must be the first phase of treatment for all patients with regional low back pain under sub. (1) (b) 1.

1. The passive, active, injection, durable medical equipment and medication treatment modalities and procedures in subs. (3) to (5), (8) and (10) may be used in sequence or simultaneously during the period of initial nonsurgical management, depending on the severity of the condition.

2. The only therapeutic injections indicated for patients with regional back pain are trigger point injections, facet joint injections, facet nerve injections, sacroiliac joint injections and epidural blocks, and their use must meet the guidelines of sub. (5).

3. After the first week of treatment, initial nonsurgical treatment must at all times contain active treatment modalities according to the guidelines in sub. (4).

4. Initial nonsurgical treatment must be provided in the least intensive setting consistent with quality health care practices.

5. Except as otherwise specified in sub. (3), passive treatment modalities in a clinic setting or requiring attendance by a health care provider are not indicated beyond 12 weeks after any passive modality other than bedrest or bracing is first initiated.

(b) Surgical evaluation or chronic management is indicated if the patient continues with symptoms and physical findings after the course of initial nonsurgical care, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities. The purpose of surgical evaluation is to determine whether surgery is indicated in the treatment of a patient who has failed to recover with initial nonsurgical care. If the patient is not a surgical candidate, then chronic management is indicated.

1. Surgical evaluation, if indicated, may begin as soon as eight weeks after, but must begin no later than 12 weeks after, beginning initial nonsurgical management. An initial recommendation or decision against surgery does not preclude surgery at a later date.

2. Surgical evaluation may include the use of appropriate medical imaging techniques. The imaging technique must be chosen on the basis of the suspected etiology of the patient's condition but the health care provider must follow the guidelines in s. DWD 81.05 (1). Medical imaging studies which do not meet these guidelines are not indicated.

3. Surgical evaluation may also include diagnostic blocks and injections. These blocks and injections are only indicated if their use is consistent with the guidelines of sub (1) (i).

4. Surgical evaluation may also include personality or psychosocial evaluation, consistent with the guidelines of sub. (1) (h).

5. Consultation with other health care providers may be appropriate as part of the surgical evaluation. The need for consultation and the choice of consultant will be determined by the findings on medical imaging, diagnostic analgesic blocks and injections, if performed, and the patient's ongoing subjective complaints and physical findings.

6. The only surgical procedures indicated for patients with regional low back pain only are decompression of a lumbar nerve root or lumbar arthrodesis, with or without instrumentation, which must meet the guidelines of sub. (6) and s. DWD 81.12 (1). For patients with failed back surgery, dorsal column stimulators or morphine pumps may be indicated and their use must meet the guidelines of sub. (6) (d).

a. If surgery is indicated, it should be offered to the patient as soon as possible. If the patient agrees to the proposed surgery, it should be performed as expeditiously as possible consistent with sound medical practice.

b. If surgery is not indicated, or if the patient does not wish to proceed with surgery, then the patient is a candidate for chronic management according to the guidelines in s. DWD 81.13.

(c) If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management which must be provided according to the standards in s. DWD 81.13.

(12) SPECIFIC TREATMENT GUIDELINES FOR RADICULAR PAIN, WITH OR WITHOUT REGIONAL LOW BACK PAIN, WITH NO OR STATIC NEUROLOGIC DEFICITS. (a) Initial

nonsurgical treatment is appropriate for all patients with radicular pain, with or without regional low back pain, with no or static neurologic deficits under sub. (1) (b) 2, and must be the first phase of treatment. It must be provided within the guidelines of sub. (11) (a) with the following modifications: Epidural blocks and nerve root and peripheral nerve blocks are the only therapeutic injections indicated for patients with radicular pain only. If there is a component of regional low back pain, therapeutic facet joint injections, facet nerve injections, trigger point injections, and sacroiliac injections may also be indicated.

(b) Surgical evaluation or chronic management is indicated if the patient continues with symptoms and physical findings after the course of initial nonsurgical care, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities. It must be provided within the guidelines of sub. (11) (b).

(c) If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered, the patient refused surgical therapy, or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with radicular pain, with or without regional back pain, with static neurologic deficits must meet all of the guidelines of s. DWD 81.13.

(13) SPECIFIC TREATMENT GUIDELINES FOR CAUDA EQUINA SYNDROME AND FOR RADICULAR PAIN, WITH OR WITHOUT REGIONAL LOW BACK PAIN, WITH PROGRESSIVE NEUROLOGIC DEFICITS. (a) Patients with cauda equina syndrome or with radicular pain, with or without regional low back pain, with progressive neurologic deficits may require immediate or emergency surgical evaluation at any time during the course of the overall treatment. The decision to proceed with surgical evaluation is made by the health care provider based on the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes, and the response to any initial nonsurgical treatments. Surgery, if indicated, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be provided within the guidelines of sub. (11) (b), except that surgical evaluation and surgical therapy may begin at any time.

(b) If the health care provider decides to proceed with a course of initial nonsurgical care for a patient with radicular pain with progressive neurologic changes, it must follow the guidelines of sub. (12) (a).

(c) If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with radicular pain, with or without regional back pain, with foot drop or progressive neurologic changes at first presentation must meet the guidelines in s. DWD 81.13.

DWD 81.07 Neck pain. (1) DIAGNOSTIC PROCEDURES FOR TREATMENT OF NECK INJURY. (a) A health care provider shall determine the nature of the condition before initiating treatment.

(b) An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the health care provider must assign the patient at each visit to the appropriate clinical category according to subds. 1 to 4. The diagnosis must be documented in the medical record. For the purposes of subds. 2 and 3, "radicular pain" means pain radiating distal to the shoulder. This subsection does not apply to fractures of the cervical spine or cervical pain due to an infectious, immunologic, metabolic, endocrine, neurologic, visceral or neoplastic disease process.

1. Regional neck pain includes referred pain to the shoulder and upper back. Regional neck pain includes the diagnoses of cervical strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury and other diagnoses for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the cervical spine and which affects the cervical region, with or without referral to the upper back or shoulder, including, but not limited to, ICD-9-CM codes 720 to 720.9, 721 to 721.0, 721.5 to 721.90, 722.3 to 722.30, 722.4, 722.6, 722.9 to 722.91, 723 to 723.3, 723.5 to 723.9, 724.5, 724.8, 724.9, 732.0, 737 to 737.9, 738.4, 738.5, 739.1, 756.1 to 756.19, 847 to 847.0, 920, 922.3, 925, and 926.1 to 926.12.

2. Radicular pain, with or without regional neck pain, with no or static neurologic deficit. This includes the diagnoses of brachialgia; cervical radiculopathy, radiculitis, or neuritis; displacement or herniation of intervertebral disc with radiculopathy, radiculitis, or neuritis; spinal stenosis with

radiculopathy, radiculitis, or neuritis; and other diagnoses for pain in the arm distal to the shoulder believed to originate with irritation of a nerve root in the cervical spine, including, but not limited to, the ICD-9-CM codes 721.1, 721.91, 722 to 722.0, 722.2, 722.7 to 722.71, 723.4, and 724 to 724.00. In these cases neurologic findings on history and examination are either absent or do not show progressive deterioration.

3. Radicular pain, with or without regional neck pain, with progressive neurologic deficit, which includes the same diagnoses as sub.b; however, in these cases there is a history of progressive deterioration in the neurologic symptoms and physical findings, including worsening sensory loss, increasing muscle weakness and progressive reflex changes.

4. Cervical compressive myelopathy, with or without radicular pain, is a condition characterized by weakness and spasticity in one or both legs and associated with any of the following: exaggerated reflexes, an extensor plantar response, bowel or bladder dysfunction, sensory ataxia or bilateral sensory changes.

(c) Laboratory tests are not indicated in the evaluation of a patient with regional neck pain, or radicular pain, except for any of the following:

1. When a patient's history, age or examination suggests infection, metabolic-endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders, such as rheumatoid arthritis or ankylosing spondylitis.

2. To evaluate potential adverse side effects of medications.

3. As part of a preoperative evaluation.

(d) Laboratory tests may be ordered at any time the health care provider suspects any of the conditions specified in par. (c), but the health care provider must justify the need for the tests ordered with clear documentation of the indications.

(e) Medical imaging evaluation of the cervical spine must be based on the findings of the history and physical examination and cannot be ordered prior to the health care provider's clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and must comply with the guidelines in s. DWD 81.05 (1). The health care provider must document the appropriate indications for any medical imaging studies obtained.

(f) EMG and nerve conduction studies are always inappropriate for the regional neck pain diagnoses in par. (b) 1. EMG and nerve conduction studies may be an appropriate diagnostic tool for radicular pain and myelopathy diagnoses in par. (b) 2 to 4 after the first three weeks of radicular or myelopathy symptoms. Repeat EMG and nerve conduction studies for radicular pain and myelopathy are not indicated unless a new neurologic symptom or finding has developed which in itself would warrant electrodiagnostic testing. Failure to improve with treatment is not an indication for repeat testing.

(f) The use of any of the following procedures or tests is not indicated for the diagnosis of any of the clinical categories in par. (b):

1. Surface electromyography or surface paraspinal electromyography.

2. Thermography.

3. Plethysmography.

4. Electronic X-ray analysis of plain radiographs.

5. Diagnostic ultrasound of the spine.

6. Somatosensory evoked potentials (SSEP) and motor evoked potentials (MEP).

(h) Computerized range of motion or strength measuring tests are not indicated during the period of initial nonsurgical management, but may be indicated during the period of chronic management when used in conjunction with a computerized exercise program, work hardening program or work conditioning program. During the period of initial nonsurgical management, computerized range of motion or strength testing can be performed but must be done in conjunction with and shall not be reimbursed separately from an office visit, chiropractic evaluation or treatment, or physical or occupational therapy evaluation or treatment.

(i) Personality or psychological evaluations may be a useful tool for evaluating patients who continue to have problems despite appropriate care. The treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, the health care provider performing the evaluation must consider all of the following:

1. Is symptom magnification occurring?

2. Does the patient exhibit an emotional reaction to the injury, such as depression, fear or anger, which is interfering with recovery?

3. Are there other personality factors or disorders which are interfering with recovery?

4. Is the patient chemically dependent?

5. Are there any interpersonal conflicts interfering with recovery?

6. Does the patient have a chronic pain syndrome or psychogenic pain?

7. In cases in which surgery is a possible treatment, are psychological factors, such as those in subds. 1 to 6 likely to interfere with the potential benefit of the surgery?

(j) Diagnostic analgesic blocks or injection studies include facet joint injection, facet nerve block, epidural differential spinal block, nerve block and nerve root block.

1. These procedures are used to localize the source of pain prior to surgery and to diagnose conditions which fail to respond to initial nonsurgical management.

2. These blocks and injections are invasive and when done as diagnostic procedures are not indicated unless noninvasive procedures have failed to establish the diagnosis.

3. Selection of patients, choice of procedure, and localization of the level of injection should be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms.

4. These blocks and injections can also be used as therapeutic modalities and as such are subject to the guidelines of sub. (5)

(k) Functional capacity assessment or evaluation is a comprehensive and objective assessment of a include, but are not necessarily limited to, neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility and measurement of postural tolerance. A functional capacity assessment or evaluation is an individualized testing process and the component tests and measurements are determined by the patient's condition and the requested information. Functional capacity assessments and evaluations are performed to determine a patient's physical capacities in general or to determine and report work tolerance for a specific job, task, or work activity.

1. Functional capacity assessment or evaluation is not necessary during the period of initial nonoperative care.

2. Functional capacity assessment or evaluation is necessary in either of the following circumstances:

a. Permanent activity restrictions and capabilities must be identified.

b. There is a question about the patient's ability to do a specific job.

(L) Consultations with other health care providers may be initiated at any time by the treating health care provider consistent with accepted medical practice.

(2) GENERAL TREATMENT GUIDELINES FOR NECK PAIN. (a) All medical care for neck pain appropriately assigned to a clinical category in par. (b) is determined by the diagnosis and clinical category in par. (b) to which the patient has been assigned. General guidelines for treatment modalities are set forth in subs. (3) to (10). Specific treatment guidelines for each clinical category are set forth in subs. (11) to (14) as follows:

1. Subsection (11) governs regional neck pain.

2. Subsection (12) governs radicular pain with static neurologic deficits.

3. Subsection (13) governs radicular pain with progressive neurologic deficits.

4. Subsection (14) governs myelopathy.

(b) The health care provider must, at each visit, reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing and opinions and information obtained from consultations with other health care providers. When the clinical category is changed the treatment plan must be appropriately modified to reflect the new clinical category. However, a change of clinical category does not in itself allow the health care provider to continue a therapy or treatment modality past the maximum duration specified in subs. (3) to (10), or to repeat a therapy or treatment previously provided for the same injury.

(c) In general a course of treatment is divided into the following three phases:

1. First, all patients with neck problems, except patients with radicular pain with progressive neurological deficit or myelopathy under sub. (1) b 3 and 4 , must be given initial nonsurgical care which may include both active and passive treatment modalities, injections, durable medical equipment and

medications. These modalities and guidelines are described in subs. (3) to (5), (8) and (10). The period of initial nonsurgical management begins with the first passive, active, injection, durable medical equipment or medication modality initiated. Initial nonsurgical treatment must result in progressive improvement as specified in sub (9).

2. Second, for patients with persistent symptoms, initial nonoperative care is followed by a period of surgical evaluation. This evaluation should be completed in a timely manner. Surgery, if indicated, should be performed as expeditiously as possible consistent with sound medical practice and subs. (6), (11) to (14) and s. DWD 81.12. The treating health care provider may do the evaluation or may refer the employee to another practitioner..

a. Patients with radicular pain with progressive neurological deficit or myelopathy may require immediate surgical therapy.

b. Any patient who has had surgery may require postoperative therapy with active and passive treatment modalities. This therapy may be in addition to any received during the period of initial nonsurgical management.

c. Surgery must follow the guidelines in subs. (6), (11) to (14) and s. DWD 81.12.

d. A decision against surgery at this time does not preclude a decision for surgery made at a later date.

3. Third, for those patients who are not candidates for or refuse surgical therapy, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be indicated. Chronic management modalities are described in s. DWD 81.13 and may include durable medical equipment as described in sub. (8).

(d) Treating health care provider may refer the employee for a consultation at any time during the course of treatment consistent with accepted medical practice.

(3) PASSIVE TREATMENT MODALITIES. (a) Except as set forth in sub (b) or s. DWD 81.04 (5) the use of passive treatment modalities in a clinical setting as set forth in subds. 3 to 9 is not indicated beyond 12 calendar weeks after any of the passive modalities in subds. 3 to 9 are initiated. There are no limitations on the use of passive treatment modalities by the employee at home.

(b) An additional 12 visits for the use of passive treatment modalities over an additional 12 months may be provided if all of the following apply:

1. The employee is released to work or is permanently totally disabled and the additional passive treatment must result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care.

2. The treatment must not be given on a regularly scheduled basis.

3. The health care provider must document in the medical record a plan to encourage the employee's independence and decreased reliance on health care providers.

4. Management of the employee's condition must include active treatment modalities during this period.

5. The additional 12 visits for passive treatment must not delay the required surgical or chronic pain evaluation required by this section.

6. Passive care is inappropriate while the employee has chronic pain syndrome.

(c) Treatment guidelines for adjustment or manipulation of joints that includes chiropractic and osteopathic adjustments or manipulations include the following:

1. Time for treatment response is three to five treatments.

2. Maximum treatment frequency is up to five times per week for the first one to two weeks decreasing in frequency thereafter.

3. Maximum treatment duration is 12 weeks.

(d) Thermal treatment includes all superficial and deep heating modalities and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool and fluidotherapy. Deep thermal modalities include diathermy, ultrasound and microwave.

1. Treatment guidelines for thermal treatment given in a clinical setting include the following:

a. Time for treatment response is two to four treatments.

b. Maximum treatment frequency is up to five times per week for the first one to three weeks decreasing in frequency thereafter.

c. Maximum treatment duration is 12 weeks of treatment in a clinical setting, but only if given in conjunction with other therapies.

2. Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks which can be applied by the patient without health care provider assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.

(e) Electrical muscle stimulation includes galvanic stimulation, TENS, interferential and microcurrent techniques.

1. Treatment guidelines for electrical muscle stimulation given in a clinical setting include the following:

a. Time for treatment response is two to four treatments.

b. Maximum treatment frequency is up to five times per week for the first one to three weeks decreasing in frequency thereafter.

c. Maximum treatment duration is 12 weeks of treatment in a clinical setting, but only if given in conjunction with other therapies.

2. Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device must be in a supervised setting in order to ensure proper electrode placement and patient education. Treatment guidelines for home use include the following:

a. Time for patient education and training is one to three sessions.

b. Patient may use the electrical stimulation device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

(f) Mechanical traction.

a. Treatment guidelines for mechanical traction given in a clinical setting include the following:

1. Time for treatment response is three treatments.

2. Maximum treatment frequency is up to three times per week for the first one to three weeks decreasing in frequency thereafter.

3. Maximum treatment duration is 12 weeks in a clinical setting, but only if used in conjunction with other therapies.

b. Home use of a mechanical traction device may be prescribed as follow-up to use of traction in a clinical setting if it has proven to be effective treatment and is expected to continue to be effective treatment. Initial use of a mechanical traction device must be in a supervised setting in order to ensure proper patient education. Treatment guidelines for home use include the following:

1. Time for patient education and training is one session.

2. A patient may use the mechanical traction device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

(g) Acupuncture treatments. Endorphin-mediated analgesic therapy includes classic acupuncture and acupressure. Treatment guidelines for acupuncture include the following:

1. Time for treatment response is three to five sessions.

2. Maximum treatment frequency is up to three times per week for one to three weeks decreasing in frequency thereafter.

3. Maximum treatment duration is 12 weeks.

(h) Manual therapy includes soft tissue and joint mobilization, therapeutic massage and manual traction. Treatment guidelines for manual therapy include the following:

1. Time for treatment response is three to five treatments.

2. Maximum treatment frequency is up to five times per week for the first one to two weeks decreasing in frequency thereafter.

3. Maximum treatment duration is 12 weeks.

(i) Phoresis includes iontophoresis and phonophoresis. Treatment guidelines for phoresis include the following:

1. Time for treatment response is three to five sessions.

2. Maximum treatment frequency is up to three times per week for the first one to three weeks decreasing in frequency thereafter.

3. Maximum treatment duration is 12 weeks.

(j) Bedrest. Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Bedrest should not be prescribed for more than seven days.

(k) Treatment guidelines for Cervical collars, spinal braces and other movement-restricting appliances include the following:

1. Bracing required for longer than two weeks must be accompanied by active muscle strengthening exercise to avoid deconditioning and prolonged disability.

2. Time for treatment response is three days.

3. Treatment frequency, limited to intermittent use during times of increased physical stress or prophylactic use at work.

4. Maximum continuous duration is up to three weeks unless patient is status postfusion.

(4) ACTIVE TREATMENT MODALITIES. (a) Active treatment modalities must be used as set forth in subds. 1 to 4. Use of active treatment modalities may extend past the 12-week limitation on passive treatment modalities, so long as the maximum duration for the active modality is not exceeded.

1. Education must teach the patient about pertinent anatomy and physiology as it relates to spinal function for the purpose of injury prevention. Education includes training on posture, biomechanics and relaxation. The maximum number of treatments is three visits, which includes an initial education and training session, and two follow-up visits.

2. Posture and work method training must instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, neck, and arms, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, exercises and simulated work tasks. The maximum number of treatments is three visits.

3. Worksite analysis and modification must examine the patient's work station, tools,and job duties. Recommendations are made for the alteration of the work station, selection of alternate tools, modification of job duties and provision of adaptive equipment. The maximum number of treatments is three visits.

4. Exercise, which is important to the success of an initial nonsurgical treatment program and a return to normal activity, must include active patient participation in activities designed to increase flexibility, strength, endurance or muscle relaxation. Exercise must, at least in part, be specifically aimed at

the musculature of the cervical spine. While aerobic exercise and extremity strengthening may be performed as adjunctive treatment, it must not be the primary focus of the exercise program.

(b) Exercises must be evaluated to determine if the desired goals are being attained. Strength, flexibility and endurance must be objectively measured. The provider may objectively measure the treatment response as often as necessary for optimal care after the initial evaluation. Subds. 1and 2 govern supervised and unsupervised exercise, except for computerized exercise programs and health clubs, which are governed by s. DWD 81.13.

1.' Supervised exercise'. One goal of an exercise program must be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition must be promoted. Treatment guidelines for supervised exercise include the following:

a. Maximum treatment frequency is three times per week for three weeks, decreasing in frequency thereafter.

b. Maximum duration is 12 weeks.

2. Unsupervised exercise must be provided in the least intensive setting appropriate to the goals of the exercise program, and may supplement or follow the period of supervised exercise. Treatment guidelines for unsupervised exercise include the following:

a. Maximum treatment frequency is up to three visits for instruction and monitoring.

b. There is no limit on the duration or frequency of exercise at home.

(5) THERAPEUUTIC INJECTIONS. (a) Injection modalities are indicated as set forth in subds. 2 to 5. Use of injections may extend past the 12-week limit on passive treatment modalities, so long as the maximum treatment for injections is not exceeded.

1. Therapeutic injections include trigger points injections, facet joint injections, facet nerve blocks, sympathetic nerve blocks, epidurals, nerve root blocks and peripheral nerve blocks. Therapeutic injections can only be given in conjunction with active treatment modalities directed to the same anatomical site.

2. Treatment guidelines for trigger point injections include the following:

a. Time for treatment response is within 30 minutes.

b. Maximum treatment frequency is once per week if a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to

facilitate objective functional gains, then trigger point injections should be redirected to other areas or discontinued. Only three injections per patient visit.

c. Maximum treatment is four injections to any one site.

3. Treatment guidelines for facet joint injections or facet nerve blocks include the following:

a. Time for treatment response is within one week.

b. Maximum treatment frequency is once every two weeks if a positive response to the first injection or block. If subsequent injections or blocks demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections or blocks should be discontinued. Only three injections or blocks per patient visit.

c. Maximum treatment is three injections or blocks to any one site.

4. Treatment guidelines for nerve root blocks include the following:

a. Time for treatment response is within one week.

b. Maximum treatment frequency, can repeat injection no sooner than two weeks after the previous injection if a positive response to the first injection. No more than three blocks per patient visit.

c. Maximum treatment is two blocks to any one site.

5. Treatment guidelines for epidural injections include the following:

a. Time for treatment response is within one week.

b. Maximum treatment frequency is once every two weeks if a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections should be discontinued. Only one injection per patient visit.

c. Maximum treatment is three injections.

(b) Permanent lytic or sclerosing injections, including radio frequency denervation of the facet joints. These injections can only be given in conjunction with active treatment modalities directed to the same anatomical site. Treatment guidelines include the following:

1. Time for treatment response is within one week.

2. Maximum treatment frequency, may repeat once for any site.

3. Maximum duration is two injections to any one site.

(c) Prolotherapy and botulinum toxin injections are not indicated in the treatment of neck problems.

(6) SURGERY, INCLUDING DECOMPRESSION PROCEDURES AND ARTHRODESIS. (a) Surgery may only be performed if it meets the specific guidelines of subs. (11) to (14) and s. DWD 81.12.

1. In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities may be provided, even if these modalities had been used in the preoperative treatment of the condition. In the postoperative period the maximum treatment duration with passive treatment modalities in a clinical setting from the initiation of the first passive modality used, except bedrest or bracing, is as follows:

a. Eight weeks following decompression or implantation of a dorsal column stimulator or morphine pump.

b. 12 weeks following arthrodesis.

(b) Repeat surgery must also meet the guidelines of subs. (11) to (14) and s. DWD 81.12.

(c) The following surgical therapies have very limited application, must meet within the guidelines listed, and a personality or psychosocial evaluation indicates that the patient is likely to benefit from the treatment.

1. Dorsal column stimulator is indicated for a patient who has neuropathic pain, is not a candidate for any other invasive therapy and has had a favorable response to a trial screening period.

2. Morphine pump is indicated for a patient who has somatic pain, is not a candidate for any other invasive therapy and has had a favorable response to a trial screening period.

(7) CHRONIC MANAGEMENT. Chronic management of neck disorders must be provided according to the guidelines in s. DWD 81.13.

(8) DURABLE MEDICAL EQUIPMENT. Durable medical equipment is indicated only as specified in pars. (b) to (e).

(b) Cervical collars, braces or supports and home cervical traction devices may be indicated within the guidelines of sub. (3) (f) and (k).

(c) For patients using electrical stimulation at home, the device and any required supplies are indicated within the guidelines of sub. (3) (e).

(d) Exercise equipment for home use, including bicycles, treadmills and stairclimbers, are indicated only within the context of a program or plan of an approved chronic management program. This equipment is not indicated during initial nonoperative care or during reevaluation and surgical therapy. If the employer has an appropriate exercise facility on its premises with the prescribed equipment, the insurer may mandate the use of that facility instead of authorizing purchase of equipment for home use.

1'.Indications'. The patient is deconditioned and requires reconditioning which can be accomplished only with the use of the prescribed exercise equipment. The health care provider must document specific reasons why the exercise equipment is necessary and cannot be replaced with other activities.

2.' Requirements'. The use of the equipment must have specific goals and there must be a specific set of prescribed activities.

(e) The following durable medical equipment is not indicated for home use for neck pain conditions:

1. Whirlpools, Jacuzzis, hot tubs and special bath or shower attachments.

2. Beds, waterbeds, mattresses, chairs, recliners and loungers.

(9) EVALUATION OF TREATMENT BY HEALTH CARE PROVIDER. (a) The health care provider must evaluate at each visit whether the treatment is medically necessary, and shall evaluate whether initial nonsurgical management is effective according to par. (b) 1 to 3.

(b) No later than the time for treatment response established for the specific modality as specified in subs. (3) to (5), the health care provider must evaluate whether the passive, active, injection or medication treatment modality has resulted in progressive improvement as specified in subs. (3) to (5).

1. The employee's subjective complaints of pain or disability are progressively improving, as evidenced by documentation in the medical record of decreased distribution, frequency or intensity of symptoms.

2. The objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury.

3. The employee's functional status, especially vocational activity, is progressively improving, as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive limitations on activity.

(c) If there is not progressive improvement in at least two categories specified in par. (b) 1 to 3, the modality must be discontinued or significantly modified or the provider must reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality can be delegated to another practitioner.

(10) SCHEDULED AND NONSCHEDULED MEDICATION. (a) Prescription of controlled substance medications scheduled under ch. 450, Stats. including, without limitation, narcotics, is indicated only for the treatment of severe acute pain. These medications are not indicated in the treatment of patients with regional neck pain after the first two weeks.

(b) Patients with radicular pain may require longer periods of treatment.

(c) The health care provider must document the rationale for the use of any scheduled medication. Treatment with nonnarcotic medication may be appropriate during any phase of treatment and intermittently after all other treatment has been discontinued. The prescribing health care provider must determine that ongoing medication is effective treatment for the patient's condition.

(11) SPECIFIC TREATMENT GUIDELINES FOR REGIONAL NECK PAIN. (a) Initial nonsurgical treatment must be the first phase of treatment for all patients with regional neck pain under sub. (1) (b) 1.

1. The active, passive, injection, durable medical equipment and medication treatment modalities and procedures in subs. (3) to (5), (8) and (10), may be used in sequence or simultaneously during the period of initial nonsurgical management depending on the severity of the condition.

2. The only therapeutic injections indicated for patients with regional neck pain are trigger point injections, facet joint injections, facet nerve blocks and epidural blocks, and their use must meet the guidelines of sub. (5).

3. After the first week of treatment, initial nonsurgical treatment must at all times contain active treatment modalities according to the guidelines of sub. (4).

4. Initial nonsurgical treatment must be provided in the least intensive setting consistent with quality health care practices.

5. Except as otherwise provided in sub. (3) passive treatment modalities in a clinic setting or requiring attendance by a health care provider are not indicated beyond 12 weeks after any passive modality other than bedrest or bracing is first initiated.

(b) Surgical evaluation or chronic management is indicated if the patient continues with symptoms and physical findings after the course of initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities. The purpose of surgical evaluation is to determine whether surgery is indicated in the treatment of a patient who has failed to recover with initial nonsurgical care. If the patient is not a surgical candidate, then chronic management is indicated.

1. Surgical evaluation if indicated may begin as soon as eight weeks after, but must begin no later than 12 weeks after, beginning initial nonsurgical management. An initial recommendation or decision against surgery does not preclude surgery at a later date.

2. Surgical evaluation may include the use of appropriate medical imaging techniques. The imaging technique must be chosen on the basis of the suspected etiology of the patient's condition but the health care provider must follow the guidelines of s. DWD 81.05 (1).

3. Surgical evaluation may also include diagnostic blocks and injections. These blocks and injections are only indicated if their use is consistent with the guidelines of sub. (1) (j).

4. Surgical evaluation may also include personality or psychosocial evaluation, consistent with the guidelines of sub. (1) (i).

5. Consultation with other health care providers may be appropriate as part of the surgical evaluation. The need for consultation and the choice of consultant will be determined by the findings on medical imaging, diagnostic analgesic blocks and injections, if performed, and the patient's ongoing subjective complaints and physical findings.

6. The only surgical procedure indicated for patients with regional neck pain only is cervical arthrodesis, with or without instrumentation, which must meet the guidelines in sub. (6). For patients with failed surgery, dorsal column stimulators or morphine pumps may be indicated consistent with the guidelines of sub. (6) (c).

a. If surgery is indicated, it should be offered to the patient as soon as possible. If the patient agrees to the proposed surgery, it should be performed as expeditiously as possible consistent with sound medical practice.

b. If surgery is not indicated or if the patient does not wish to proceed with surgical therapy, then the patient is a candidate for chronic management.

(c) If the patient continues with symptoms and objective physical findings after surgery has been rendered or the patient refuses surgery or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management according to s. DWD 81.13.

(12). SPECIFIC TREATMENT GUIDELINES FOR RADICULAR PAIN, WITH OR WITHOUT REGIONAL NECK PAIN, WITH NO OR STATIC NEUROLOGIC DEFICITS. (a) Initial nonsurgical treatment is appropriate for all patients with radicular pain, with or without regional neck pain, with no or static neurologic deficits under sub. (1) (b) 2, and must be the first phase of treatment. It must be provided within the guidelines of sub. (11) (a), with the following modifications: Epidural blocks and nerve root and peripheral nerve blocks are the only therapeutic injections indicated for patients with radicular pain only. If there is a component of regional neck pain, therapeutic facet joint injections, facet nerve blocks and trigger point injections may also be indicated.

(b) Surgical evaluation or chronic management is indicated if the patient continues with symptoms and physical findings after the course of initial nonsurgical care, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities. It must be provided within the guidelines of sub. (11) (b), with the following modifications: The only surgical procedures indicated for patients with radicular pain are decompression of a cervical nerve root which must meet the guidelines of subs. (6) and s. DWD 81.12 (1) (b) and cervical arthrodesis, with or without instrumentation. For patients with failed surgery, dorsal column stimulators or morphine pumps may be indicated consistent with sub. (6) (c).

(c) If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered, the patient refused surgical therapy, or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including

regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with radicular pain, with or without regional neck pain, with static neurologic changes must meet all of the guidelines s. DWD 81.13.

(13) SPECIFIC TREATMENT GUIDELINES FOR RADICULAR PAIN,WITH OR WITHOUT REGIONAL NECK PAIN, WITH PROGRESSIVE NEUROLOGIC DEFICITS. (a) Patients with radicular pain, with or without regional neck pain, with progressive neurologic deficits may require immediate or emergency evaluation at any time during the course of their overall treatment. The decision to proceed with surgical evaluation is made by the health care provider based on the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes and the response to any nonsurgical treatments. Surgery, if indicated, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be provided within the guidelines of sub. (11) (b) with the following modifications:

1. Surgical evaluation and surgical therapy may begin at any time.

2. The only surgical procedures indicated for patients with radicular pain are decompression of a cervical nerve root which must meet the guidelines of sub. (6) and s. DWD 81.12 (1) (b), or cervical arthrodesis, with or without instrumentation. For patients with failed back surgery, dorsal column stimulators or morphine pumps may be indicated consistent with the guidelines of sub. (6) (c).

(b) If the health care provider decides to proceed with a course of nonsurgical care for a patient with radicular pain with progressive neurologic changes, it must follow the guidelines of sub. (12) (a).

(c) If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with radicular pain, with or without regional neck pain, with progressive neurologic changes at first presentation must meet all of the guidelines in s. DWD 81.13.

(14) SPECIFIC TREATMENT GUIDELINES FOR MYELOPATHY. (a) Patients with myelopathy may require emergency surgical evaluation at any time during the course of their overall treatment. The decision to proceed with surgical evaluation is made by the health care provider based on

the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes, and the response to any nonsurgical treatments. Surgery, if indicated, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be provided within the guidelines of sub. (6) (b), with the following modifications:

1. Surgical evaluation and surgical therapy may begin at any time.

2. The only surgical procedures indicated for patients with myelopathy are anterior or posterior decompression of the spinal cord, or cervical arthrodesis with or without instrumentation. For patients with failed back surgery, dorsal column stimulators or morphine pumps may be indicated consistent with the guidelines of sub. (6) (c).

(b) If the health care provider decides to proceed with a course of nonsurgical care for a patient with myelopathy, it must follow the guidelines of sub. (12) (a).

(c) If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with myelopathy must meet all of the guidelines of s. DWD 81.13.

DWD 81.08 Thoracic back pain. (1) DIAGNOSTIC PROCEDURES FOR TREATMENT OF THORACIC BACK INJURY. (a) A health care provider shall determine the nature of the condition before initiating treatment.

(b) An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the health care provider must assign the patient at each visit to the consistency appropriate clinical category according to subds. 1 to 3. The diagnosis must be documented in the medical record. For the purposes of subds. 2 and 3, "radicular pain" means pain radiating in a dermatomal distribution around the chest or abdomen. This subsection does not apply to fractures of the thoracic spine or thoracic back pain due to an infectious, immunologic, metabolic, endocrine, neurologic, visceral or neoplastic disease process.

1. Regional thoracic back pain includes the diagnoses of thoracic strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury and any other diagnosis for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the thoracic spine and which effects the thoracic region, including, but not limited to, ICD-9-CM codes 720 to 720.9, 721 to 721.0, 721.5 to 721.90, 722.3 to 722.30, 722.4, 722.6, 722.9 to 722.91, 723 to 723.3, 723.5 to 723.9, 724.5, 724.8, 724.9, 732.0, 737 to 737.9, 738.4, 738.5, 739.1, 756.1 to 756.19, 847 to 847.0, 920, 922.3, 925, and 926.1 to 926.12.

2. Radicular pain, with or without regional thoracic back pain, includes the diagnoses of thoracic radiculopathy, radiculitis, or neuritis; displacement or herniation of intervertebral disc with radiculopathy, radiculitis, or neuritis; spinal stenosis with radiculopathy, radiculitis, or neuritis; and any other diagnoses for pain believed to originate with irritation of a nerve root in the thoracic spine, including, but not limited to, the ICD-9-CM codes 721.1, 721.91, 722 to 722.0, 722.2, 722.7 to 722.71, 723.4, and 724 to 724.00.

3. Thoracic compressive myelopathy, with or without radicular pain, is a condition characterized by weakness and spasticity in one or both legs and associated with any of the following: exaggerated reflexes, an extensor plantar response, bowel or bladder dysfunction, sensory ataxia or bilateral sensory changes.

(c) Laboratory tests are not indicated in the evaluation of a patient with regional thoracic back pain, or radicular pain, except when a patient's history, age or examination suggests infection, metabolic-endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders, such as rheumatoid arthritis or ankylosing spondylitis, or side effects of medications. Laboratory tests may be ordered at any time the health care provider suspects any of these conditions, but the health care provider must justify the need for the tests ordered with clear documentation of the indications. Laboratory tests may also be ordered as part of a preoperative evaluation.

(d) Medical imaging evaluation of the thoracic spine must be based on the findings of the history and physical examination and cannot be ordered prior to the health care provider's clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and must comply with the guidelines in s. DWD 81.05 (1). The health care provider must document the appropriate indications for any medical imaging studies obtained.

(e) EMG and nerve conduction studies are always inappropriate for regional thoracic back pain and radicular pain under par. (b) 1 to 3.

(f) The use of any of the following procedures or tests is not indicated for the diagnosis of any of the clinical categories in par. (b) 1 to 3:

1. Surface electromyography or surface paraspinal EMG.

2. Thermography.

3. Plethysmography.

4. Electronic X-ray analysis of plain radiographs.

5. Diagnostic ultrasound of the spine.

6. Somatosensory evoked potentials (SSEP) and motor evoked potentials (MEP).

(g) Computerized range of motion or strength measuring tests are not necessary during the period of initial nonsurgical care, but may be necessary during a period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. During the period of initial nonoperative care computerized range of motion or strength testing can be performed but must be done in conjunction with an office visit, chiropractic evaluation or treatment, or physical or occupational therapy evaluation or treatment.

(h) Personality or psychological evaluations may be a useful tool for evaluating patients who continue to have problems despite appropriate care. The treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, the health care provider performing the evaluation must consider all of the following:

1. Is symptom magnification occurring?

2. Does the patient exhibit an emotional reaction to the injury, such as depression, fear or anger, which is interfering with recovery?

3. Are there other personality factors or disorders which are interfering with recovery?

4. Is the patient chemically dependent?

5 Are there any interpersonal conflicts interfering with recovery?

6. Does the patient have a chronic pain syndrome or psychogenic pain?

7. In cases in which surgery is a possible treatment, are psychological factors, such as those listed in subd. 1 to 7, likely to interfere with the potential benefit of the surgery?

(i) Diagnostic analgesic blocks or injection studies include facet joint injection, facet nerve block, epidural differential spinal block, nerve block and nerve root block.

1. These procedures are used to localize the source of pain prior to surgery and to diagnose conditions which fail to respond to initial nonoperative care.

2. These blocks and injections are invasive and when done as diagnostic procedures only are not indicated unless noninvasive procedures have failed to establish the diagnosis.

3. Selection of patients, choice of procedure and localization of the level of injection should be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms.

4. These blocks and injections can also be used as therapeutic modalities and as such are subject to the guidelines of sub. (5).

(j) Functional capacity assessment or evaluation is a comprehensive and objective assessment of a patient's ability to perform work tasks. The components of a functional capacity assessment or evaluation include, but are not limited to, neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility and measurement of postural tolerance. A functional capacity assessment or evaluation is an individualized testing process and the component tests and measurements are determined by the patient's condition and the requested information. Functional capacity assessments and evaluations are performed to determine and report a patient's physical capacities in general or to determine work tolerance for a specific job, task or work activity.

1. Functional capacity assessment or evaluation is not necessary during the period of initial nonoperative care.

2. Functional capacity assessment or evaluation is necessary in either of the following circumstances:

a. Permanent activity restrictions and capabilities must be identified.

b. There is a question about the patient's ability to do a specific job.

(k) Consultations with other health care providers can be initiated at any time by the treating health care provider consistent with standard medical practice.

(2) GENERAL TREATMENT GUIDELINES FOR THORACIC BACK PAIN. (a) All medical care for thoracic back pain, appropriately assigned to a category of sub. (1) (b) is determined by the diagnosis and clinical category in sub. (1) (b) to which the patient has been assigned. General guidelines for treatment modalities are set forth in subs. (3) to (10). Specific treatment guidelines for each clinical category are set forth in subs. (11) to (13) as follows:

1. Subsection (11) governs regional thoracic back pain.

2. Subsection (12) governs radicular pain.

3. Subsection (m) governs myelopathy.

(b) The health care provider must, at each visit, reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing and opinions and information obtained from consultations with other health care providers. When the clinical category is changed the treatment plan must be appropriately modified to reflect the new clinical category. However, a change of clinical category does not in itself allow the health care provider to continue a therapy or treatment modality past the maximum duration specified in this section or to repeat a therapy or treatment previously provided for the same injury.

(c) In general a course of treatment is divided into the following three phases:

1. First, all patients with thoracic back problems, except patients with myelopathy under sub. (1) (b) 3, , must be given initial nonoperative care which may include active and passive treatment modalities, injections, durable medical equipment and medications. These modalities and guidelines are described in subs. (3) to (5), (8) and (10). The period of initial nonsurgical treatment begins with the first clinical passive, active, injection, durable medical equipment or medication modality initiated. Initial nonsurgical treatment must result in progressive improvement as specified in sub. (9).

2. Second, for patients with persistent symptoms, initial nonsurgical management is followed by a period of surgical evaluation. This evaluation should be completed in a timely manner. Surgery, if indicated, should be performed as expeditiously as possible consistent with sound medical practice and

subs. (6), (11) to (13) and s. DWD 81.12 The treating health care provider may do the evaluation or may refer the employee to another practitioner.

a. Patients with myelopathy may require immediate surgical therapy.

b. Any patient who has had surgery may require postoperative therapy with active and passive treatment modalities. This therapy may be in addition to any received during the period of initial nonsurgical care.

c. Surgery must follow the guidelines in subs. (6), (10) to (13) and s. DWD 81.12.

d. A decision against surgery at this time does not preclude a decision for surgery made at a later date in light of new clinical information.

3. Third, for those patients who are not candidates for or refuse surgical therapy, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be indicated. Chronic management modalities are described in s. DWD 81.13, and may also include durable medical equipment as described in sub. (8).

(d) A treating health care provider may refer the employee for a consultation at any time during the course of treatment consistent with accepted medical practice.

(3) PASSIVE TREATMENT MODALITIES. (a) Except as set forth in par. (b) or s. DWD 81.04 (5) the use of passive treatment modalities in a clinical setting as set forth in pars. (c) to (i) is not indicated beyond 12 calendar weeks after any of the passive modalities in pars. (c) to (i) are initiated. There are no limitations on the use of passive treatment modalities by the employee at home.

(b) An additional 12 visits for the use of passive treatment modalities over an additional 12 months may be provided if all of the following apply:

1. The employee is released to work or is permanently totally disabled and the additional passive treatment must result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care.

2. The treatment must not be given on a regularly scheduled basis.

3. The health care provider must document in the medical record a plan to encourage the employee's independence and decreased reliance on health care providers.

4. Management of the employee's condition must include active treatment modalities during this period.

5. The additional 12 visits for passive treatment must not delay the required surgical or chronic pain evaluation required by these guidelines.

6. Passive care is inappropriate while the employee has chronic pain syndrome.

(c) Adjustment or manipulation of joints includes chiropractic and osteopathic adjustments or manipulations. Treatment guidelines include the following:

1. Time for treatment response is three to five treatments.

2. Maximum treatment frequency is up to five times per week for the first one to two weeks decreasing in frequency thereafter.

3. Maximum treatment duration is 12 weeks.

(d) Thermal treatment includes all superficial and deep heating modalities and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool and fluidotherapy. Deep thermal modalities include diathermy, ultrasound and microwave. Treatment guidelines for thermal treatment include the following:

1. Treatment given in a clinical setting.

a. Time for treatment response is two to four treatments.

b. Maximum treatment frequency is up to five times per week for the first one to three weeks decreasing in frequency thereafter.

c. Maximum treatment duration is 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

1. Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs and cold soaks which can be applied by the patient without health care provider assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.

(e) Electrical muscle stimulation includes galvanic stimulation, TENS, interferential and microcurrent techniques. Treatment guidelines for electrical muscle stimulation include the following:

1. Treatment guidelines for treatment given in a clinical setting.

a. Time for treatment response is two to four treatments.

b. Maximum treatment frequency is up to five times per week for the first one to three weeks decreasing in frequency thereafter.

c. Maximum treatment duration is 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

1. Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device must be in a supervised setting in order to ensure proper electrode placement and patient education. Treatment guidelines for home use include the following:

a. Maximum time for patient education and training is up to three sessions.

b. Patient may use the electrical stimulation device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

(f) Treatment guidelines for mechanical traction include the following:

1. Treatment given in a clinical setting.

a. Time for treatment response is three treatments.

b. Maximum treatment frequency is up to three times per week for the first one to three weeks decreasing in frequency thereafter.

c. Maximum treatment duration is 12 weeks in a clinical setting but only if used in conjunction with other therapies.

2. Home use of a mechanical traction device may be prescribed as follow-up to use of traction in a clinical setting if it has proven to be effective treatment and is expected to continue to be effective treatment. Initial use of a mechanical traction device must be in a supervised setting in order to ensure proper patient education. Treatment guidelines for home use include the following:

a. Maximum time for patient education and training is one session.

b. A patient may use the mechanical traction device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

(g) Treatment guidelines for acupuncture treatments. Endorphin-mediated analgesic therapy includes classic acupuncture and acupressure. Treatment guidelines include the following:

a. Time for treatment response is three to five sessions.

b. Maximum treatment frequency is up to three times per week for one to three weeks decreasing in frequency thereafter.

c. Maximum treatment duration is 12 weeks.

(h) Manual therapy includes soft tissue and joint mobilization, therapeutic massage and manual traction. Treatment guidelines for manual therapy include the following:

1. Time for treatment response is three to five treatments.

2. Maximum treatment frequency is up to five times per week for the first one to two weeks decreasing in frequency thereafter.

3. Maximum treatment duration is 12 weeks.

(i) Phoresis includes iontophoresis and phonophoresis. Treatment guidelines for phoresis includes the following:

1. Time for treatment response is three to five sessions.

2. Maximum treatment frequency is up to three times per week for the first one to three weeks decreasing in frequency thereafter.

3. Maximum treatment duration is 12 weeks.

(j) Bedrest. Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Bedrest should not be prescribed for more than seven days.

(k) Treatment guidelines for spinal braces and other movement-restricting appliances. Bracing required for longer than two weeks must be accompanied by active muscle strengthening exercise to avoid deconditioning and prolonged disability. Treatment guidelines includes the following:

1. Time for treatment response is three days.

2. Maximum treatment frequency is limited to intermittent use during times of increased physical stress or prophylactic use at work.

3. Maximum continuous duration is three weeks unless patient is status postfusion.

(4) ACTIVE TREATMENT MODALITIES. (a) Active treatment modalities must be used as set forth in pars. (b) to (f). Use of active treatment modalities may extend past the 12-week limit on passive treatment modalities, so long as the maximum durations for the active treatment modalities are not exceeded.

(b) Education must teach the patient about pertinent anatomy and physiology as it relates to spinal function for the purpose of injury prevention. Education includes training on posture, biomechanics and relaxation. The maximum number of treatments is three visits, which includes an initial education and training session and two follow-up visits.

(c) Posture and work method training must instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, back and arms, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, exercises, and simulated work tasks. The maximum number of treatments is three visits.

(d) Worksite analysis and modification must examine the patient's work station, tools and job duties. Recommendations are made for the alteration of the work station, selection of alternate tools, modification of job duties and provision of adaptive equipment. The maximum number of treatments is three visits.

(e) Exercise, which is important to the success of an initial nonsurgical treatment program and a return to normal activity, must include active patient participation in activities designed to increase flexibility, strength, endurance or muscle relaxation. Exercise must, at least in part, be specifically aimed at the musculature of the thoracic spine. While aerobic exercise and extremity strengthening may be performed as adjunctive treatment this shall not be the primary focus of the exercise program. Exercises shall be evaluated to determine if the desired goals are being attained. Strength, flexibility and endurance shall be objectively measured. The provider may objectively measure the treatment response as often as necessary for optimal care after the initial evaluation. Subds. 1 and 2 govern supervised and unsupervised exercise, except for computerized exercise programs and health clubs, which are governed by s. DWD 81.13.

1.’ Guidelines for supervised exercise’. One goal of an exercise program must be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition must be promoted. Treatment guidelines include the following:

a. Maximum treatment frequency is three times per week for three weeks and should decrease with time thereafter.

b. Maximum duration is 12 weeks.

2. ‘Guidelines for unsupervised exercise’. Unsupervised exercise must be provided in the least intensive setting appropriate to the goals of the exercise program and may supplement or follow the period of supervised exercise. Treatment guidelines include the following:

a. Maximum treatment frequency is one to three visits for instruction and monitoring.

b. There is no limit on the duration and frequency of exercise at home.

(5) THERAPEUTIC INJECTIONS. (a) Injection modalities are indicated as set forth in pars. (a) to (c). Use of injections may extend past the 12-week limit on passive treatment modalities, so long as the maximum treatment for injections is not exceeded.

1. Therapeutic injections include trigger points injections, facet joint injections, facet nerve blocks, sympathetic nerve blocks, epidurals, nerve root blocks and peripheral nerve blocks. Therapeutic injections can only be given in conjunction with active treatment modalities directed to the same anatomical site.

2. Treatment guidelines for trigger point injections include the following:

a. Time for treatment response is within 30 minutes.

b. Maximum treatment frequency is once per week if a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then trigger point injections should be redirected to other areas or discontinued. No more than three injections per patient visit.

c. Maximum treatment is four injections to any one site.

3. Treatment guidelines for facet joint injections or facet nerve blocks include the following:

a. Time for treatment response is within one week.

b. Maximum treatment frequency is once every two weeks if a positive response to the first injection or block. If subsequent injections or blocks demonstrate diminishing control of symptoms or fail

to facilitate objective functional gains, then injections or blocks should be discontinued. Only three injections or blocks per patient visit.

c. Maximum treatment is three injections or blocks to any one site.

3. Treatment guidelines for nerve root blocks include the following:

a. Time for treatment response is within one week.

b. Maximum treatment frequency, can repeat injection two weeks after the previous injection if a positive response to the first block. Only three injections per patient visit.

c. Maximum treatment is two blocks to any one site.

4. Treatment guidelines for epidural injections include the following:

a. Time for treatment response is within one week.

b. Maximum treatment frequency is once every two weeks if a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections should be discontinued. Only one injection per patient visit.

c. Maximum treatment is three injections.

(b) Permanent lytic or sclerosing injections, including radio frequency denervation of the facet joints. These injections can only be given in conjunction with active treatment modalities directed to the same anatomical site. Treatment guidelines include the following:

1. Time for treatment response is within one week.

2. Optimum treatment frequency, may repeat once for any site.

3. Maximum duration is two injections to any one site.

(c) Prolotherapy and botulinum toxin injections are not indicated in the treatment of thoracic back problems.

(6) SURGERY INCLUDING DECOMPRESSION PROCEDURES. (a) Surgery may only be performed if it meets the specific guidelines of subs. (11) to (13) and s. DWD 81.12.

(b) In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities may be provided, even if these modalities had been used in the preoperative treatment of the condition. In the postoperative period the maximum treatment duration with passive

treatment modalities in a clinical setting from the initiation of the first passive modality used, except bedrest or bracing, is as follows:

1. Eight weeks following decompression or implantation of a dorsal column stimulator or morphine pump.

2. 12 weeks following arthrodesis.

(c) Repeat surgery must also meet the guidelines of subs. (11) to (13) and s. DWD 81.12.

(d) The surgical therapies in subds. 1 and 2 have very limited application and require a personality or psychosocial evaluation which indicates that the patient is likely to benefit from the treatment.

1. Dorsal column stimulator is indicated for a patient who has neuropathic pain, and is not a candidate for any other invasive therapy, and has had a favorable response to a trial screening period.

2. Morphine pump is indicated for a patient who has somatic pain, and is not a candidate for any other invasive therapy, and has had a favorable response to a trial screening period.

(7) CHRONIC MANAGEMENT. Chronic management of thoracic back pain must be provided according to s. DWD 81.13.

(8) DURABLE MEDICAL EQUIPMENT. (a) Durable medical equipment is indicated only in certain specific situations as specified in pars. (b) to (e).

(b) Braces or supports may be indicated within the guidelines of sub. (3) (k)

(c) For patients using electrical stimulation or mechanical traction devices at home, the device and any required supplies are indicated within the guidelines of sub. (3) (e) and (f).

(d) Exercise equipment for home use, including bicycles, treadmills and stairclimbers, are indicated only within the context of a program or plan of an approved chronic management program. This equipment is not indicated during initial nonoperative care or during reevaluation and surgical therapy. If the employer has an appropriate exercise facility on its premises with the prescribed equipment, the insurer may mandate the use of that facility instead of authorizing purchase of equipment for home use.

1.' Indications'. The patient is deconditioned and requires reconditioning which can be accomplished only with the use of the prescribed exercise equipment. The health care provider must document specific reasons why the exercise equipment is necessary and cannot be replaced with other activities.

2.’ Requirements’. The use of the equipment must have specific goals and there must be a specific set of prescribed activities.

(e) The following durable medical equipment is not indicated for home use for thoracic back pain conditions:

1. Whirlpools, Jacuzzis, hot tubs, special bath or shower attachments.

2. Beds, waterbeds, mattresses, chairs, recliners or loungers.

(9) EVALUATION OF TREATMENT BY HEALTH CARE PROVIDER. (a) The health care provider must evaluate at each visit whether the treatment is medically necessary, and must evaluate whether initial nonsurgical management is effective according to subds. 1 to 3. No later than the time for treatment response established for the specific modality as specified in subs. (3) to (5), the health care provider must evaluate whether the passive, active, injection or medication treatment modality is resulting in progressive improvement as specified in subds. 1 to 3.

1. The employee's subjective complaints of pain or disability are progressively improving, as evidenced by documentation in the medical record of decreased distribution, frequency, or intensity of symptoms.

2. The objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury.

3. The employee's functional status, especially vocational activity, is progressively improving, as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive limitations on activity.

(b) If there is not progressive improvement in at least two categories specified in par. (a) 1 to 3, the modality must be discontinued or significantly modified or the provider must reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality can be delegated to another practitioner.

(10) SCHEDULED AND NONSCHEDULED MEDICATION. (a) Prescription of controlled substance medications scheduled under ch. 450, Stats., including, without limitation, narcotics, is indicated only for the treatment of severe acute pain. These medications are not indicated in the treatment of patients with regional thoracic back pain after the first two weeks.

(b) Patients with radicular pain may require longer periods of treatment.

(c) The health care provider must document the rationale for the use of any scheduled medication. Treatment with nonnarcotic medication may be appropriate during any phase of treatment and intermittently after all other treatment has been discontinued. The prescribing health care provider must determine that ongoing medication is effective treatment for the patient's condition.

(11) SPECIFIC TREATMENT GUIDELINES FOR REGIONAL THORACIC BACK PAIN. (a) Initial nonsurgical treatment must be the first phase of treatment for all patients with regional thoracic back pain under sub. (1) (b) 1.

1. The active, passive, injection, durable medical equipment, and medication treatment modalities and procedures in subs. (3) to (5), (8) and (10) may be used in sequence or simultaneously during the period of initial nonsurgical management, depending on the severity of the condition.

2. The only therapeutic injections indicated for patients with regional thoracic back pain are trigger point injections, facet joint injections, facet nerve blocks and epidural blocks, and their use must meet the guidelines of sub. (5).

3. After the first week of treatment, initial nonsurgical management must at all times contain active treatment modalities according to the guidelines of sub. (4)

4. Initial nonsurgical treatment must be provided in the least intensive setting consistent with quality health care practices.

5. Except as provided in sub. (3), passive treatment modalities in a clinic setting or requiring attendance by a health care provider are not indicated beyond 12 weeks after any passive modality other than bedrest or bracing is first initiated.

(b) Surgical evaluation or chronic management is indicated if the patient continues with symptoms and objective physical findings after the course of initial nonsurgical care, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities. The purpose of surgical evaluation is to determine whether surgery is indicated in the treatment of a patient who has failed to recover with initial nonsurgical care. If the patient is not a surgical candidate, then chronic management is indicated.

1. Surgical evaluation may begin as soon as eight weeks after, but must begin no later than 12 weeks after, beginning initial nonsurgical management. An initial recommendation or decision against surgical therapy does not preclude surgery at a later date.

2. Surgical evaluation may include the use of appropriate medical imaging techniques. The imaging technique must be chosen on the basis of the suspected etiology of the patient's condition but the health care provider must follow the guidelines in s. DWD 81.05 (1). Medical imaging studies which do not meet these guidelines are not indicated.

3. Surgical evaluation may also include diagnostic blocks and injections. These blocks and injections are only indicated if their use is consistent with the guidelines of sub. (1) (i).

4. Surgical evaluation may also include personality or psychosocial evaluation, consistent with the guidelines of sub. (1) (h).

5. Consultation with other health care providers may be appropriate as part of the surgical evaluation. The need for consultation and the choice of consultant will be determined by the findings on medical imaging, diagnostic analgesic blocks and injections, if performed, and the patient's ongoing subjective complaints and objective physical findings.

6. The only surgical procedure indicated for patients with regional thoracic back pain only is thoracic arthrodesis with or without instrumentation, which must meet the guidelines of sub. (6) and s. DWD 81.12 (1) (c). For patients with failed surgery, dorsal column stimulators or morphine pumps may be indicated consistent with sub. (6) (d).

a. If surgery is indicated, it should be offered to the patient as soon as possible. If the patient agrees to the proposed surgery it should be performed as expeditiously as possible consistent with sound medical practice.

b. If surgery is not indicated or if the patient does not wish to proceed with surgery, then the patient is a candidate for chronic management.

(d) If the patient continues with symptoms and objective physical findings after surgery has been rendered or the patient refuses surgery or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational

activities, then the patient may be a candidate for chronic management according to the guidelines of s. DWD 81.13.

(12) SPECIFIC TREATMENT GUIDELINES FOR RADICULAR PAIN. (a) Initial nonsurgical treatment is appropriate for all patients with radicular pain under sub. (1) (b) 2 and must be the first phase of treatment. It must be provided within the guidelines of sub. (11) (a), with the following modifications. Epidural blocks and nerve root and peripheral nerve blocks are the only therapeutic injections indicated for patients with radicular pain only. If there is a component of regional thoracic back pain, therapeutic facet joint injections, facet nerve blocks, and trigger point injections may also be indicated.

(b) Surgical evaluation or chronic management is indicated if the patient continues with symptoms and physical findings after the course of initial nonsurgical care, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities. It shall be provided within the guidelines of sub. (11) (b) with the following modifications. The only surgical procedures indicated for patients with radicular pain are decompression or arthrodesis. For patients with failed surgery, dorsal column stimulators or morphine pumps may be indicated consistent with sub. (6) (c).

(c) If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refused surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with radicular pain, with or without regional thoracic back pain must meet all of the guidelines of s. DWD 81.13.

(13) SPECIFIC TREATMENT GUIDELINES FOR MYELOPATHY. (a) Patients with myelopathy may require emergency surgical evaluation at any time during the course of their overall treatment. The decision to proceed with surgical evaluation is made by the health care provider based on the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes and the response to any nonsurgical treatments. Surgery, if indicated, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be provided within the guidelines of sub. (11) (b) with the following modifications:

1. Surgical evaluation and surgical therapy may begin at any time.

2. The only surgical procedures indicated for patients with myelopathy are decompression and arthrodesis. For patients with failed surgery, dorsal column stimulators or morphine pumps may be indicated consistent with sub. (6) (c).

(b) If the health care provider decides to proceed with a course of nonsurgical care for a patient with myelopathy, it must follow the guidelines of sub. (12) (a).

(c) If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with myelopathy must meet all of the guidelines of s. DWD 81.13.

DWD 81.09 Upper extremity disorders. (1) DIAGNOSTIC PROCEDURES FOR TREATMENT OF UPPER EXTREMITY DISORDERS (UED). (a) A health care provider shall determine the nature of an upper extremity disorder before initiating treatment.

(b) An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the health care provider must at each visit assign the patient to the appropriate clinical category according to subds. 1 to 6. The diagnosis must be documented in the medical record. Patients may have multiple disorders requiring assignment to more than one clinical category. This section does not apply to upper extremity conditions due to a visceral, vascular, infectious, immunological, metabolic, endocrine, systemic neurologic, or neoplastic disease process, fractures, lacerations, amputations, or sprains or strains with complete tissue disruption.

1.’ Epicondylitis’. This clinical category includes medial epicondylitis and lateral epicondylitis, ICD-9-CM codes 726.31 and 726.32.

2. ‘Tendonitis of the forearm, wrist and hand’. This clinical category encompasses any inflammation, pain, tenderness, or dysfunction or irritation of a tendon, tendon sheath, tendon insertion or musculotendinous junction in the upper extremity at or distal to the elbow due to mechanical injury or irritation, including, but not limited to, the diagnoses of tendonitis, tenosynovitis, tendovaginitis,

peritendinitis, extensor tendinitis, de Quervain's syndrome, intersection syndrome, flexor tendinitis, and trigger digit, including, but not limited to, ICD-9-CM codes 726.4, 726.5, 726.8, 726.9, 726.90, 727, 727.0, 727.00, 727.03, 727.04, 727.05, and 727.2.

3. 'Nerve entrapment syndromes'. This clinical category encompasses any compression or entrapment of the radial, ulnar or median nerves, or any of their branches, including, but not limited to, carpal tunnel syndrome, pronator syndrome, anterior interosseous syndrome, cubital tunnel syndrome, Guyon's canal syndrome, radial tunnel syndrome, posterior interosseous syndrome, and Wartenburg's syndrome, including, but not limited to, ICD-9-CM codes 354, 354.0, 354.1, 354.2, 354.3, 354.8, and 354.9.

4. 'Muscle pain syndromes'. This clinical category encompasses any painful condition of any of the muscles of the upper extremity, including the muscles responsible for movement of the shoulder and scapula, characterized by pain and stiffness, including, but not limited to, the diagnoses of chronic nontraumatic muscle strain, repetitive strain injury, cervicobrachial syndrome, tension neck syndrome, overuse syndrome, myofascial pain syndrome, myofasciitis, nonspecific myalgia, fibrositis, fibromyalgia, and fibromyositis, including, but not limited to, ICD-9-CM codes 723.3, 729.0, 729.1, 729.5, 840, 840.3, 840.5, 840.6, 840.8, 840.9, 841, 841.8, 841.9, and 842.

5.' Shoulder impingement syndromes, including tendonitis, bursitis and related conditions'. This clinical category encompasses any inflammation, pain, tenderness, dysfunction, or irritation of a tendon, tendon insertion, tendon sheath, musculotendinous junction or bursa in the shoulder due to mechanical injury or irritation, including, but not limited to, the diagnoses of impingement syndrome, supraspinatus tendonitis, infraspinatus tendonitis, calcific tendonitis, bicipital tendonitis, subacromial bursitis, subcoracoid bursitis, subdeltoid bursitis and rotator cuff tendinitis, including, but not limited to, ICD-9-CM codes 726.1 to 726.2, 726.9, 726.90, 727 to 727.01, 727.2, 727.3, 840, 840.4, 840.6, 840.8, and 840.9.

6.'Traumatic sprains or strains of the upper extremity'. This clinical category encompasses an instantaneous or acute injury, as a result of a single precipitating event to the ligaments or the muscles of the upper extremity including, without limitation, ICD-9-CM codes 840 to 842.19. Injuries to muscles as a result of repetitive use, or occurring gradually over time without a single precipitating trauma, are

considered muscle pain syndromes under subd. 4. Injuries with complete tissue disruption are not subject to this subdivision.

(c) Certain laboratory tests may be indicated in the evaluation of a patient with upper extremity disorder to rule out infection, metabolic-endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders such as rheumatoid arthritis, or side effects of medications. Laboratory tests may be ordered at any time the health care provider suspects any of these conditions, but the health care provider must justify the need for the tests ordered with clear documentation of the indications.

(d) Medical imaging evaluation of upper extremity disorders must be based on the findings of the history and physical examination and cannot be ordered before the health care provider's clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and must comply with the guidelines in s. DWD 81.05. The health care provider must document the appropriate indications for any medical imaging studies obtained.

(e) EMG and nerve conduction studies are only appropriate for nerve entrapment disorders and recurrent nerve entrapment after surgery.

(f) The following diagnostic procedures or tests are not indicated for diagnosis of upper extremity disorders:

1. Surface electromyography.

2. Thermography.

3. Somatosensory evoked potentials (SSEP) and motor evoked potentials (MEP).

(g) The following diagnostic procedures or tests are considered adjuncts to the physical examination and are not necessary separately from the office visit.

1. Vibrometry.

2. Neurometry.

3. Semmes-Weinstein monofilament testing.

4. Algometry.

(h) Computerized range of motion or strength measuring tests are not indicated during the period of initial nonsurgical management, but may be indicated during the period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning

program. During the period of initial nonsurgical management, computerized range of motion or strength testing can be performed but must be done in conjunction with an office visit with a practitioner's evaluation or treatment.

(i) Personality or psychosocial evaluations may be a useful tool for evaluating patients who continue to have problems despite appropriate initial nonsurgical care. The treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, the health care provider performing the evaluation must consider all of the following:

1. Is symptom magnification occurring?

2. Does the patient exhibit an emotional reaction to the injury, such as depression, fear or anger, which is interfering with recovery?

3. Are there other personality factors or disorders which are interfering with recovery?

4. Is the patient chemically dependent?

5. Are there any interpersonal conflicts interfering with recovery?

6. Does the patient have a chronic pain syndrome or psychogenic pain?

7. In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?

(j) Diagnostic analgesic blocks or injection studies.

1. These procedures are used to localize the source of pain and to diagnose conditions which fail to respond to appropriate initial nonsurgical management.

2. Selection of patients, choice of procedure and localization of the site of injection should be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms.

3. These blocks and injections can also be used as therapeutic modalities and as such are subject to the guidelines of sub. (5)

(k) Functional capacity assessment or evaluation is a comprehensive and objective assessment of a patient's ability to perform work tasks. The components of a functional capacity assessment or evaluation include, but are not limited to, neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility and measurement of postural tolerance. A functional capacity assessment or evaluation is an individualized testing process and the component tests and measurements are determined by the patient's condition and the required information. Functional capacity assessments and evaluations are performed to determine and report a patient's physical capacities in general or to determine work tolerance for a specific job, task or work activity.

1. Functional capacity assessment or evaluation is not indicated during the first 12 weeks of initial nonsurgical treatment.

2. Functional capacity assessment or evaluation is indicated after the first 12 weeks of care in either of the following circumstances:

a. Activity restrictions and capabilities must be identified.

b. There is a question about the patient's ability to return to do a specific job.

3. A functional capacity evaluation is not appropriate to establish baseline performance before treatment, or for subsequent assessments, to evaluate change during or after treatment.

4. Only one completed functional capacity evaluation is indicated per injury.

(L) Consultations with other health care providers can be initiated at any time by the treating health care provider consistent with accepted medical practice.

(2) GENERAL TREATMENT GUIDELINES FOR UPPER EXTREMITY DISORDERS. (a) All medical care for upper extremity disorders, appropriately assigned to a category of sub. (1) (b) is determined by the diagnosis and clinical category in sub. (1) (b) to which the patient has been assigned. General guidelines for treatment modalities are set forth in subs. (3) to (10). Specific treatment guidelines for each clinical category are set forth in subs. (11) to (16) as follows:

1. Subsection (k) governs epicondylitis.

2. Sub. (L) governs tendonitis of the forearm, wrist and hand.

3. Subsection (m) governs upper extremity nerve entrapment syndromes.

4. Subsection (n) governs upper extremity muscle pain syndromes.

5. Subsection (o) governs shoulder impingement syndromes.

6. Subsection (p) governs traumatic sprains and strains of the upper extremity.

(b) The health care provider must at each visit reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing and opinions, and information obtained from consultations with other health care providers. When the clinical category is changed the treatment plan must be appropriately modified to reflect the new clinical category and these changes must be recorded in the medical record. However, a change of clinical category does not in itself allow the health care provider to continue a therapy or treatment modality past the maximum duration specified in subs. (3) to (10) or to repeat a therapy or treatment previously provided for the same injury, unless the treatment or therapy is subsequently delivered to a different part of the body.

(c) When treating more than one clinical category or body part for which the same treatment modality is appropriate, then the treatment modality should be applied simultaneously, if possible, to all indicated areas.

(d) In general a course of treatment must be divided into the following three phases:

1. First, all patients with an upper extremity disorder must be given initial nonsurgical management, unless otherwise specified. Initial nonsurgical management may include any combination of the passive, active, injection, durable medical equipment and medication treatment modalities listed in subs. (3) to (5), (8) and (10), appropriate to the clinical category. The period of initial nonsurgical treatment begins with the first passive, active, injection, durable medical equipment or medication modality initiated. Initial nonsurgical treatment must result in progressive improvement as specified in sub. (9).

2. Second, for patients with persistent symptoms, initial nonsurgical management is followed by a period of surgical evaluation. This evaluation should be completed in a timely manner. Surgery, if indicated, should be performed as expeditiously as possible consistent with sound medical practice and subs. (6), (11) to (16) and s. DWD 81.12. The treating health care provider may do the evaluation or may refer the employee to another practitioner.

a. Any patient who has had surgery may require postoperative therapy with active and passive treatment modalities. This therapy can be in addition to any received during the period of initial nonsurgical management.

b. Surgery must follow the guidelines in subs. (6), (11) to (16) and s. DWD 81.12

c. A decision against surgery at this time does not preclude a decision for surgery made at a later date.

3. Third, for those patients who are not candidates for surgery or refuse surgery, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be indicated. Chronic management modalities are described in s. DWD 81.13 and may include durable medical equipment is described in sub. (8).

(e) A treating health care provider may refer the employee for a consultation at any time during the course of treatment consistent with accepted medical practice.

(3) PASSIVE TREATMENT MODALITIES. (a) Except as set forth in par. (b) or s. DWD 81.04 (5) the use of passive treatment modalities in a clinical setting as set forth in par. (b) 3 to 8 is not indicated beyond 12 calendar weeks after any of the passive modalities in par. (b) 3 to 8 are initiated. There are no limitations on the use of passive treatment modalities by the employee at home.

(b) An additional 12 visits for the use of passive treatment modalities over an additional 12 months may be provided if all of the following apply:

1. The employee is released to work or is permanently totally disabled and the additional passive treatment must result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care.

2. The treatment must not be given on a regularly scheduled basis.

3. The health care provider must document in the medical record a plan to encourage the employee's independence and decreased reliance on health care providers.

4. Management of the employee's condition must include active treatment modalities during this period.

5. The additional 12 visits for passive treatment must not delay the required surgical or chronic pain evaluation required by this chapter.

6. Passive care is inappropriate while the employee has chronic pain syndrome.

(c) Treatment guidelines for adjustment or manipulation of joints that includes chiropractic and osteopathic adjustments or manipulations include the following:

1. Time for treatment response is three to five treatments.

2. Maximum treatment frequency is up to five times per week the first one to two weeks decreasing in frequency thereafter.

3. Maximum treatment duration is 12 weeks.

(d) Thermal treatment includes all superficial and deep heating and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool and fluidotherapy. Deep thermal modalities include diathermy ultrasound and microwave.

1. Treatment guidelines for thermal treatment given in a clinical setting are the following:

a. Time for treatment response is two to four treatments.

b. Maximum treatment frequency is up to five times per week for the first one to three weeks, decreasing in frequency thereafter.

c. Maximum treatment duration is 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

2. Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs and cold soaks which can be applied by the patient without health care provider assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.

(e) Electrical muscle stimulation includes galvanic stimulation, TENS, interferential and microcurrent techniques.

1.Treatment guidelines for electrical muscle stimulation given in a clinical setting include the following:

a. Time for treatment response is two to four treatments.

b. Maximum treatment frequency is up to five times per week for the first one to three weeks, decreasing in frequency thereafter.

c. Maximum treatment duration is 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

2. Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device must be in a supervised setting in order to ensure proper electrode placement and patient education. Treatment guidelines for home use include the following:

a. Time for patient education and training is one to three sessions.

b. Patient may use the electrical stimulation device unsupervised for one month, at which time effectiveness of the treatment must be reevaluated by the provider before continuing home use of the device.

(f) Guidelines for acupuncture treatments. Endorphin-mediated analgesic therapy includes classic acupuncture and acupressure. Treatment guidelines include the following:

1. Time for treatment response is three to five sessions.

2. Maximum treatment frequency is up to three times per week for the first one to three weeks, decreasing in frequency thereafter.

3. Maximum treatment duration is 12 weeks.

(g) Phoresis includes phonopheresis and iontophoresis. Treatment guidelines for phoresis include the following:

1. Time for treatment response is three to five sessions.

2. Maximum treatment frequency is up to three times per week for the first one to three weeks, decreasing in frequency thereafter.

3. Maximum treatment duration is nine sessions of either iontophoresis or phonophoresis, or combination, to any one site, with a maximum duration of 12 weeks for all treatment.

(h) Manual therapy includes soft tissue and joint mobilization and therapeutic massage. Treatment guidelines for manual therapy include the following:

1. Time for treatment response is three to five treatments.

2. Maximum treatment frequency is up to five times per week for the first one to two weeks decreasing in frequency thereafter.

3. Maximum treatment duration is 12 weeks.

(i) Treatment guidelines for splints, braces and other movement-restricting appliances are included in sudb. 1 to 3. Bracing required for longer than two weeks must be accompanied by active motion exercises to avoid stiffness and prolonged disability:

1. Time for treatment response is ten days.

2. Maximum treatment frequency is limited to intermittent use during times of increased physical stress or prophylactic use at work.

3. Maximum continuous duration is eight weeks. Prophylactic use is allowed indefinitely.

(j) *Rest*. Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Total restriction of use of an affected body part should not be prescribed for more than two weeks, unless rigid immobilization is required. In cases of rigid immobilization, active motion exercises at adjacent joints should begin no later than two weeks after application of the immobilization.

(4) ACTIVE TREATMENT MODALITIES. (a) Active treatment modalities must be used as set forth in subds. 1 to 4. Use of active treatment modalities may extend past the 12-week limitation on passive treatment modalities so long as the maximum treatment for the active treatment modality is not exceeded.

1. Education must teach the patient about pertinent anatomy and physiology as it relates to upper extremity function for the purpose of injury prevention. Education includes training on posture, biomechanics and relaxation. The maximum number of treatments is three visits, which include an initial education and training session, and two follow-up visits.

2. Posture and work method training must instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, neck and arms, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, exercises, and simulated work tasks. The maximum number of treatments is three visits.

3. Worksite analysis and modification must examine the patient's work station, tools, and job duties. Recommendations are made for the alteration of the work station, selection of alternate tools,

modification of job duties and provision of adaptive equipment. The maximum number of treatments is three visits.

4. Exercise, which is important to the success of a nonsurgical treatment program and a return to normal activity, must include active patient participation in activities designed to increase flexibility, strength, endurance or muscle relaxation. Exercise must, at least in part, be specifically aimed at the musculature of the upper extremity. While aerobic exercise may be performed as adjunctive treatment this must not be the primary focus of the exercise program.

(b) Exercises must be evaluated to determine if the desired goals are being attained. Strength, flexibility or endurance must be objectively measured. The provider may objectively measure the treatment response as often as necessary for optimal care after the initial evaluation.

(c) Subds. 1 and 2 govern supervised and unsupervised exercise, except for computerized exercise programs and health clubs, which are governed by s. DWD 81.13.

1. Guidelines for supervised exercise. One goal of an exercise program must be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition must be promoted. Treatment guidelines for supervised exercise include the following:

a. Maximum treatment frequency is up to three times per week for three weeks and should decrease with time thereafter.

b. Maximum duration is 12 weeks.

2. Unsupervised exercise must be provided in the least intensive setting and may supplement or follow the period of supervised exercise.

(5) THERAPEUTIC INJECTIONS. (a) Therapeutic injections include injections of trigger points, sympathetic nerves, peripheral nerves and soft tissues. Therapeutic injections can only be given in conjunction with active treatment modalities directed to the same anatomical site. Use of injections may extend past the 12-week limitation on passive modalities, so long as the maximum treatment for injections in pars. (b) to (d) is not exceeded.

(b) Treatment guidelines for trigger point injections are as follows:

1. Time for treatment response is within 30 minutes.

2. Maximum treatment frequency is once per week to any one site if a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then trigger point injections should be redirected to other areas or discontinued. No more than three injections to different sites are necessary per patient visit and

3. Maximum treatment is four injections to any one site over the course of treatment.

(c) Treatment guidelines for soft tissue injections are included in subds. 1 to 3. Soft tissue injections include injections of a bursa, tendon, tendon sheath, ganglion, tendon insertion, ligament or ligament insertion.

1. Time for treatment response is within one week.

2. Maximum treatment frequency is once per month to any one site if a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections should be discontinued. Only three injections to different sites per patient visit.

3. Maximum treatment is three injections to any one site over the course of treatment.

(d) Treatment guidelines for injections for median nerve entrapment at the carpal tunnel include the following:

1. Time for treatment response is within one week.

2. Maximum treatment frequency, can repeat injection in one month if a positive response to the first injection. Only three injections to different sites per patient visit.

3. Maximum treatment is two injections to any one site over the course of treatment.

(6) SURGERY. (a) Surgery may only be performed if it meets applicable guidelines in par. (11) to (16) and s. DWD 81.12.

(b) In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities may be provided, even if these modalities had been used in the preoperative treatment of the condition. In the postoperative period the maximum treatment duration with passive treatment modalities in a clinical setting from initiation of the first passive modality used, except bedrest or bracing, is as follows:

1. 16 weeks for rotator cuff repair, acromioclavicular ligament repair, or any surgery for a clinical category in this section which requires joint reconstruction.

2. Eight weeks for all other surgery for clinical categories in this section.

(c) Repeat surgery must also meet the guidelines of subs. (11) to (16) and s. DWD 81.12.

(7) CHRONIC MANAGEMENT. Chronic management of upper extremity disorders must be provided according to the guidelines in s. DWD 81.13

(8) DURABLE MEDICAL EQUIPMENT. (a) Durable medical equipment is indicated only in the situations specified in pars. (b) to (e).

(b) Splints, braces, straps, or supports may be indicated as specified in sub. (3) (i).

(c) For patients using an electrical stimulation device at home, the device and any required supplies are indicated within the guidelines of sub. (3) (e). The insurer may provide the equipment if it is comparable to that prescribed by the health care provider.

(d) Exercise equipment for home use, including bicycles, treadmills and stairclimbers, are indicated only within the context of a program or plan of an approved chronic management program. This equipment is not indicated during initial nonsurgical care or during reevaluation and surgical therapy. If the employer has an appropriate exercise facility on its premises with the prescribed equipment the insurer may mandate use of that facility instead of authorizing purchase of the equipment for home use.

1.’ Indications’. The patient is deconditioned and requires reconditioning which can be accomplished only with the use of the prescribed exercise equipment. The health care provider must document specific reasons why the exercise equipment is necessary and cannot be replaced with other activities.

2. ‘Requirements’. The use of the equipment must have specific goals and there must be a specific set of prescribed activities.

(e) The following durable medical equipment is not indicated for home use for the upper extremity disorders specified in subs. (11) to (16):

1. Whirlpools, Jacuzzis, hot tubs and special bath or shower attachments.

2. Beds, waterbeds, mattresses, chairs, recliners and loungers.

(9) EVALUATION OF TREATMENT BY HEALTH CARE PROVIDER. (a) The health care provider must evaluate at each visit whether the treatment is medically necessary and whether initial nonsurgical treatment is effective according to par. (b) 1 to 3.

(b) No later than the time for treatment response established for the specific modality as specified in subs. (3) to (5) the health care provider must evaluate whether the passive, active, injection or medication treatment modality is resulting in progressive improvement as specified in subds. 1 to 3.

1. The employee's subjective complaints of pain or disability are progressively improving, as evidenced by documentation in the medical record of decreased distribution, frequency, or intensity of symptoms.

2. The objective clinical findings are progressively improving as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury.

3. The employee's functional status, especially vocational activity, is progressively improving, as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive limitations on activity.

(c) If there is not progressive improvement in at least two categories specified in par. (b) 1 to 3, the modality must be discontinued or significantly modified or the provider must reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality can be delegated to an allied health professional directly providing the treatment, but remains the ultimate responsibility of the treating health care provider.

(10) SCHEDULED AND NONSCHEDULED MEDICATION. (a) Prescription of controlled substance medications scheduled under ch. 450, Stats., including, without limitation, narcotics, is indicated only for the treatment of severe acute pain. Therefore, these medications are not routinely indicated in the treatment of patients with upper extremity disorders.

(b) The health care provider must document the rationale for the use of any scheduled medication. Treatment with nonscheduled medication may be appropriate during any phase of treatment and intermittently after all other treatment has been discontinued. The prescribing health care provider must determine that ongoing medication is effective treatment for the patient's condition.

(10) SPECIFIC TREATMENT GUIDELINES FOR EPICONDYLITIS. (a) Initial nonsurgical management is appropriate for all patients with epicondylitis and must be the first phase of treatment.

1. The passive, active, injection, durable medical equipment and medication treatment modalities and procedures specified in subs. (3) to (5), (8) and (10) may be used in sequence or simultaneously during the period of initial nonsurgical management depending on the severity of the condition. After the first week of treatment, initial nonsurgical care must at all times include active treatment modalities according to sub. (4).

2. Initial nonsurgical management must be provided in the least intensive setting consistent with quality health care practices.

3. Except as provided in sub. (3) the use of passive treatment modalities in a clinic setting or requiring attendance by a health care provider for a period in excess of 12 weeks is not indicated.

4. Use of home-based treatment modalities with monitoring by the treating health care provider may continue for up to 12 months. At any time during this period the patient may be a candidate for chronic management if surgery is ruled out as an appropriate treatment.

(b) If the patient continues with symptoms and objective physical findings after initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then surgical evaluation or chronic management is indicated. The purpose and goal of surgical evaluation is to determine whether surgery is indicated for the patient who has failed to recover with appropriate nonsurgical care or chronic management.

1. Surgical evaluation, if indicated, must begin no later than 12 months after beginning initial nonsurgical management.

2. Surgical evaluation may include the use of appropriate laboratory and electrodiagnostic testing within the guidelines of sub. (1) if not already obtained during the initial evaluation. Repeat testing is not indicated unless there has been an objective change in the patient's condition which in itself would warrant further testing. Failure to improve with therapy does not, by itself, warrant further testing.

3. Plain films may be appropriate if there is a history of trauma, infection, or inflammatory disorder and are subject to the general guidelines in s. DWD 81.05 (1). Other medical imaging studies are not indicated.

4. Surgical evaluation may also include personality or psychological evaluation consistent with the guidelines of sub. (1) (i).

5. Consultation with other health care providers is an important part of surgical evaluation of a patient who fails to recover with appropriate initial nonsurgical management. The need for consultation and the choice of consultant will be determined by the diagnostic findings and the patient's condition.

6. If surgery is indicated, it may not be performed until 12 months after initial nonsurgical management was begun except in a patient who has had resolution of symptoms with appropriate treatment followed by a recurrence with intractable pain.

7. If surgery is not indicated, or if the patient does not wish to proceed with surgery, then the patient is a candidate for chronic management. An initial recommendation or decision against surgery does not preclude surgery at a later date.

(c) If the patient continues with symptoms and objective physical findings after surgery or the patient refused surgery or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management according to s. DWD 81.13.

(12) SPECIFIC TREATMENT GUIDELINES FOR TENDONITIS OF FOREARM, WRIST AND HAND. (a) Except as provided in par. (b) 3 initial nonsurgical management is appropriate for all patients with tendonitis and must be the first phase of treatment. Any course or program of initial nonsurgical management must meet all of the guidelines of sub. (11) (a).

(b) If the patient continues with symptoms and objective physical findings after initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then surgical evaluation or chronic management is indicated. Surgical evaluation and surgical therapy must meet all of the guidelines of sub. (11) (b) with the following modifications in subds. 1 to 3:

1. For patients with a specific diagnosis of de Quervain's syndrome, surgical evaluation and surgical therapy, if indicated, may begin after only two months of initial nonsurgical management.

2. For patients with a specific diagnosis of trigger finger or trigger thumb, surgical evaluation and potential surgical therapy may begin after only one month of initial nonsurgical management.

3. For patients with a locked finger or thumb, surgery may be indicated immediately without any preceding nonsurgical management.

(c) If the patient continues with symptoms and objective physical findings after surgery, or the patient refused surgery or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with tendonitis must meet all of the guidelines of s. DWD 81.13.

(13) SPECIFIC TREATMENT GUIDELINES FOR NERVE ENTRAPMENT SYNDROME. (a) Initial nonsurgical management is appropriate for all patients with nerve entrapment syndromes, except as specified in par. (b) 2, and must be the first phase of treatment. Any course or program of initial nonsurgical management must meet all of the guidelines of sub. (11) (k) with the following modifications. Nonsurgical management may be inappropriate for patients with advanced symptoms and signs of nerve compression, such as abnormal two-point discrimination, motor weakness or muscle atrophy, or for patients with symptoms of nerve entrapment due to acute trauma. In these cases, immediate surgical evaluation may be indicated.

(b) If the patient continues with symptoms and objective physical findings after 12 weeks of initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then surgical evaluation or chronic management is indicated. Surgical evaluation and surgical therapy must meet all of the guidelines of sub. (11) (b) with the following modifications:

1. Surgical evaluation may begin, and surgical therapy may be provided, if indicated, after 12 weeks of initial nonsurgical management, except where immediate surgical evaluation is indicated under par. (a).

2. Surgery is indicated if an EMG confirms the diagnosis, or if there has been temporary resolution of symptoms lasting at least seven days with local injection.

3. If there is neither a confirming EMG or appropriate response to local injection, or if surgery has been previously performed at the same site, surgery is not indicated.

(c) If the patient continues with symptoms and objective physical findings after all surgery, or the patient refused surgery therapy or the patient was not a candidate for surgery therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with nerve entrapment syndromes must meet all of the guidelines in s. DWD 81.13.

(14) SPECIFIC TREATMENT GUIDELINES FOR MUSCLE PAIN SYNDROMES.

(a) Initial nonsurgical management is appropriate for all patients with muscle pain syndromes and must be the first phase of treatment. Any course or program of initial nonsurgical management must meet all of the guidelines of sub. (11) (a).

(b) Surgery is not indicated for the treatment of muscle pain syndrome.

(c) If the patient continues with symptoms and objective physical findings after initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with muscle pain syndrome must meet all of the guidelines in s. DWD 81.13.

(15) SPECIFIC TREATMENT GUIDELINES FOR SHOULDER IMPINGMENT SYNDROME.

(a) Initial nonsurgical management is appropriate for all patients with shoulder impingement syndromes without clinical evidence of rotator cuff tear and must be the first phase of treatment. Any course or program of initial nonsurgical management must meet all of the guidelines of sub. (11) (a), except for the following:

1. Continued nonsurgical management may be inappropriate, and early surgical evaluation may be indicated, for patients with any of the following:

a. Clinical findings of rotator cuff tear.

b. Acute rupture of the proximal biceps tendon.

2. Use of home-based treatment modalities with monitoring by the health care provider may continue for up to six months. At any time during this period the patient may be a candidate for chronic management if surgery is ruled out as an appropriate treatment.

(b) If the patient continues with symptoms and objective physical findings after six months of initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then surgical evaluation or chronic management is indicated. Surgical evaluation and surgical therapy must meet all of the guidelines of sub. (11) (b) with the following modifications:

1. Surgical evaluation must begin no later than six months after beginning initial nonsurgical management.

2. Diagnostic injection, arthrography, CT-arthrography or MRI scanning may be indicated as part of the surgical evaluation.

3. The only surgical procedures indicated for patients with shoulder impingement syndrome and related conditions are rotator cuff repair, acromioplasty, excision of distal clavicle, excision of bursa, removal of adhesion or repair of proximal biceps tendon, all of which must meet the guidelines of s. DWD 81.12 (2).

(c) If the patient continues with symptoms and objective physical findings after surgery, or the patient refused surgery or was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with shoulder impingement syndrome must meet the guidelines of s. DWD 81.13.

(16) SPECIFIC TREATMENT GUIDELINES FOR TRAUMATIC SPRAINS AND STRAINS OF THE UPPER EXTREMITY. (a) Initial nonsurgical management must be the first phase of treatment for all patients with traumatic sprains and strains of the upper extremity without evidence of complete tissue disruption. Any course or program of initial nonsurgical management must meet all of the guidelines of sub. (11).

(b) Surgery is not indicated for the treatment of traumatic sprains and strains, unless there is clinical evidence of complete tissue disruption. Patients with complete tissue disruption may need immediate surgery.

(c) If the patient continues with symptoms and objective physical findings after 12 weeks of initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of

daily life, including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management must meet all of the guidelines in s. DWD 81.13.

DWD 81.10 Reflex sympathetic dystrophy of the upper and lower extremities. (1) SCOPE.

(a) This clinical category encompasses any condition of the upper or lower extremity characterized by concurrent presence in the involved extremity of five of the following conditions: edema; local skin color change of red or purple; osteoporosis in underlying bony structures demonstrated by radiograph; local dyshidrosis; local abnormality of skin temperature regulation; reduced passive range of motion in contiguous joints; local alteration of skin texture of smooth or shiny; or typical findings of reflex sympathetic dystrophy on bone scan. This clinical category includes, but is not limited to, the diagnoses of reflex sympathetic dystrophy, causalgia, Sudek's atrophy, algoneurodystrophy, and shoulder-hand syndrome, and including, but not limited to, ICD-9-CM codes 337.9, 354.4, and 733.7.

(b) Reflex sympathetic dystrophy occurs as a complication of another preceding injury. The treatment guidelines of this section refer to the treatment of the body part affected by the reflex sympathetic dystrophy. The treatment for any condition not affected by reflex sympathetic dystrophy continues to be subject to whatever treatment guidelines otherwise apply. Any treatment under this section for the reflex sympathetic dystrophy may be in addition to treatment received for the original condition.

(c) Thermography may be used in the diagnosis of reflex sympathetic dystrophy and is considered an adjunct to physical examination.

(2) INITIAL NONSURGICAL INVOLVEMENT. (a) Initial nonsurgical management is appropriate for all patients with reflex sympathetic dystrophy and must be the first phase of treatment. Any course or program of initial nonsurgical management is limited to the modalities specified in pars. (b) to (i).

(b) Therapeutic injection modalities. The only injections allowed for reflex sympathetic dystrophy are sympathetic block, intravenous infusion of steroids or sympatholytics, or epidural block.

1. Unless medically contraindicated, sympathetic blocks or the intravenous infusion of steroids or sympatholytics must be used if reflex sympathetic dystrophy has continued for four weeks and the employee remains disabled as a result of the reflex sympathetic dystrophy. Treatment guidelines include the following:

a. Time for treatment response is within 30 minutes.

b. Maximum treatment frequency permits a repeat injection at a site if there was a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections must be discontinued. No more than three injections to different sites per patient visit.

c. Maximum treatment duration may be continued as long as injections control symptoms and facilitate objective functional gains, if the period of improvement is progressively longer with each injection.

2. Epidural block may only be performed in patients who had an incomplete improvement with sympathetic block or intravenous infusion of steroids or sympatholytics.

(c) Only the passive treatment modalities set forth in pars. (d) to (g) are indicated. These passive treatment modalities in a clinical setting or requiring attendance by a health care provider are not indicated beyond 12 weeks from the first modality initiated for treatment of the reflex sympathetic dystrophy.

(d) Thermal treatment includes all superficial and deep heating and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool and fluidotherapy. Deep thermal modalities include diathermy, ultrasound and microwave.

1.Treatment guidelines for thermal treatment given in a clinical setting include the following:

a. Time for treatment response is two to four treatments.

b. Maximum treatment frequency is up to five times per week for the first one to three weeks, decreasing in frequency thereafter.

c. Maximum treatment duration is 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies specified in this subsection.

2. Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs and cold soaks which can be applied by the patient without professional assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.

(e) Treatment guidelines for desensitizing procedures, such as stroking or friction massage, stress loading, and contrast baths include the following:

1. Time for treatment response is three to five treatments.

2. Maximum treatment frequency in a clinical setting is up to five times per week for the first one to two weeks decreasing in frequency thereafter.

3. Maximum treatment duration in a clinical setting is 12 weeks. Home use of desensitizing procedures may be prescribed at any time during the course of treatment.

(f) Electrical stimulation includes galvanic stimulation, TENS, interferential, and microcurrent techniques.

1.Treatment guidelines for electrical stimulation treatment given in a clinical setting are as follows:

a. Time for treatment response is two to four treatments.

b. Maximum treatment frequency is up to five times per week for the first one to three weeks, decreasing in frequency thereafter.

c. Maximum treatment duration is 12 weeks of treatment in a clinical setting, but only if given in conjunction with other therapies.

2. Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device must be in a supervised setting in order to ensure proper electrode placement and patient education. Treatment guidelines for home use are as follows:

a. Time for patient education and training is one to three sessions.

b. Patient may use the electrical stimulation device unsupervised for one month, at which time effectiveness of the treatment must be reevaluated by the provider before continuing home use of the device.

(g) Acupuncture treatments. Endorphin-mediated analgesic therapy includes classic acupuncture and acupressure. Treatment guidelines for acupuncture include the following:

1. Time for treatment response is three to five sessions.

2. Maximum treatment frequency is up to three times per week for the first one to three weeks, decreasing in frequency thereafter.

3. Maximum treatment duration is 12 weeks.

(h) Active treatment includes supervised and unsupervised exercise. After the first week of treatment, initial nonsurgical management must include exercise. Exercise is essential for a return to normal activity and must include active patient participation in activities designed to increase flexibility, strength, endurance or muscle relaxation. Exercise must be specifically aimed at the involved musculature. Exercises must be evaluated to determine if the desired goals are being attained. Strength, flexibility or endurance must be objectively measured. The provider may objectively measure the treatment response as often as necessary for optimal care.

1.' Supervised exercise'. One goal of a supervised exercise program must be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition must be promoted. Treatment guidelines for supervised exercise include the following:

a. Maximum treatment frequency is up to five times per week for three weeks. Should decrease in frequency thereafter.

b. Maximum duration is12 weeks.

2. Unsupervised exercise must be provided in the least intensive setting and may supplement or follow the period of supervised exercise. Maximum duration is unlimited.

(i) Oral medications may be indicated in accordance with accepted medical practice.

(3). SURGERY. (a) Surgical sympathectomy may only be performed in patients who had a sustained but incomplete improvement with sympathetic blocks by injection.

(b) Dorsal column stimulator or morphine pump may be indicated for a patient with neuropathic pain unresponsive to all other treatment modalities who is not a candidate for any other therapy and has had a favorable response to a trial screening period. Use of these devices is indicated only if a personality or psychosocial evaluation indicates that the patient is likely to benefit from this treatment.

(4) CHRONIC MANAGEMENT. If the patient continues with symptoms and objective physical findings after surgery, or the patient refuses surgery, or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management must satisfy all of the treatment guidelines in s. DWD 81.13.

DWD 81.11 Inpatient Hospitalization Guidelines. (1) GENERAL PRINCIPLES. (a) Hospitalization is characterized as inpatient if the patient spends at least one night in the hospital.

(b) Unless the patient's condition requires special care, only ward or semiprivate accommodations are indicated. The admitting health care provider must document the special care needs.

(c) Admissions before the day of surgery are indicated only if they are medically necessary to stabilize the patient before surgery. Admission before the day of surgery to perform any or all of a preoperative work-up which could have been completed as an outpatient is not indicated.

(d) Inpatient hospitalization solely for physical therapy, bedrest or administration of injectable drugs is indicated only if the treatment is otherwise indicated and the patient's condition makes the patient unable to perform the activities of daily life and participate in the patient's own treatment and self-care.

(e) Discharge from the hospital must be at the earliest possible date consistent with proper health care.

(2) SPECIFIC GUIDELINES FOR HOSPITAL ADMISSION OF PATIENTS WITH LOW BACK PAIN. (a) Hospitalization for low back pain is indicated in the circumstances in pars. (b) to (e).

(b) When the patient experiences incapacitating pain as evidenced by inability to mobilize for activities of daily living, for example unable to ambulate to the bathroom, and in addition, the intensity of service during admission meets any of the following:

1. Physical therapy is necessary at least twice daily for assistance with mobility. Heat, cold, ultrasound and massage therapy alone do not meet this criterion.

2. Muscle relaxants or narcotic analgesics are necessary intramuscularly or intravenously for a minimum of three injections in 24 hours. Need for parenteral analgesics is determined by either of the following:

a. An inability to take oral medications or diet (N.P.O.).

b. An inability to achieve relief with aggressive oral analgesics.

(c) For surgery which is otherwise indicated according to s. DWD 81.12 and is appropriately scheduled as an inpatient procedure.

(d) For evaluation and treatment of cauda equina syndrome according to s. DWD 81.06 (13).

(e) For evaluation and treatment of foot drop or progressive neurologic deficit according to s. DWD 81.06 (13).

DWD 81.12 Guidelines for surgical procedures. (1) SPINAL SURGERY. Initial nonsurgical, surgical and chronic management guidelines are also included in s. DWD 81.06, low back pain; s. DWD 81.07, neck pain; and s. DWD 81.08, thoracic back pain.

(b) *Surgical decompression of lumbar nerve root or roots*. Surgical decompression of a lumbar nerve root or roots includes, but is not limited to, the following lumbar procedures: laminectomy, laminotomy, discectomy, microdiscectomy, percutaneous discectomy, or foraminotomy. The procedure at each nerve root is subject independently to the requirements of subds. 1 and 2.

1. 'Diagnoses'. Surgical decompression of a lumbar nerve root may be performed for the following diagnoses:

a. Intractable and incapacitating regional low back pain with positive nerve root tension signs and an imaging study showing displacement of lumbar intervertebral disc which impinges significantly on a nerve root or the thecal sac, ICD-9-CM code 722.10.

b. Sciatica, ICD-9-CM code 724.3.

c. Lumbosacral radiculopathy or radiculitis, ICD-9-CM code 724.4.

2. 'Indications'. Both of the following conditions in this subdivision and subd. 3 must be satisfied to indicate that the surgery is reasonably required. For the response to nonsurgical care the employee's condition includes one of the following:

a. Failure to improve with a minimum of eight weeks of initial nonsurgical care.

b. Cauda equina syndrome, ICD-9-CM code 344.6, 344.60, or 344.61.

c. Progressive neurological deficits.

3. 'Clinical findings'. The employee exhibits one of the findings of this subd. 3 a in combination with the test results of this subd. 3 b or, in the case of diagnosis in subd. 1 a , a decompression of the lumbar nerve root is the appropriate treatment for the patient's condition.

a. Subjective sensory symptoms in a dermatomal distribution which may include radiating pain, burning, numbness, tingling, or paresthesia, or objective clinical findings of nerve root specific motor

deficit, including, but not limited to, foot drop or quadriceps weakness, reflex changes, or positive EMG; and

b. Medical imaging test results that correlate with the level of nerve root involvement consistent with both the subjective and objective findings.

(c) *Surgical decompression of a cervical nerve root.* Surgical decompression of a cervical nerve root or roots includes, but is not limited to, the following cervical procedures; laminectomy, laminotomy, discectomy, foraminotomy with or without fusion. For decompression of multiple nerve roots the procedure at each nerve root is subject to the guidelines of subds. 1 and 2.

1. 'Diagnoses'. Surgical decompression of a cervical nerve root may be performed for the following diagnoses:

a. Displacement of cervical intervertebral disc, ICD-9-CM code 722.0, excluding fracture.

b. Cervical radiculopathy or radiculitis, ICD-9-CM code 723.4, excluding fracture.

2. 'Indications'. The requirements in this subdivision and subd. 3 must be satisfied to indicate that surgery is reasonably required. For the response to nonsurgical care, the employee's condition includes one of the following:

a. Failure to improve with a minimum of eight weeks of initial nonsurgical care.

b. Cervical compressive myelopathy.

c. Progressive neurologic deficits.

3. 'Clinical findings'. The employee exhibits one of the findings of this subd. 3 a in combination with the test results of this subd. 3 b.

a. Subjective sensory symptoms in a dermatomal distribution which may include radiating pain, burning, numbness, tingling or paresthesia or objective clinical findings of nerve root specific motor deficit, reflex changes or positive EMG; and

b. Medical imaging test results that correlate with the level of nerve root involvement consistent with both the subjective and objective findings.

(d) *Lumbar arthrodesis with or without instrumentation*. 'Indications'. One of the following conditions must be satisfied to indicate that the surgery is reasonably required:

1. Unstable lumbar vertebral fracture, ICD-9-CM codes 805.4, 805.5, 806.4, and 806.5.

2. For a second or third surgery only, documented reextrusion or redisplacement of lumbar intervertebral disc, ICD-9-CM code 722.10, after previous successful disc surgery at the same level and new lumbar radiculopathy with or without incapacitating back pain, ICD-9-CM code 724.4. Documentation under this subdivision must include an MRI or CT scan or a myelogram; or

3. Traumatic spinal deformity including a history of compression (wedge) fracture or fractures, ICD-9-CM code 733.1, and demonstrated acquired kyphosis or scoliosis, ICD-9-CM codes 737.1, 737.10, 737.30, 737.41, and 737.43.

4. Incapacitating low back pain, ICD-9-CM code 724.2, for longer than three months, and one of the following conditions involving lumbar segments L-3 and below is present:

a. For the first surgery only, degenerative disc disease, ICD-9-CM code 722.4, 722.5, 722.6, or 722.7, with postoperative documentation of instability created or found at the time of surgery, or positive discogram at one or two levels.

b. Pseudoarthrosis, ICD-9-CM code 733.82.

c. For the second or third surgery only, previously operated disc.

d. Spondylolisthesis.

(e) 'Contraindications'. Lumbar arthrodesis is not indicated as the first primary surgical procedure for a new, acute lumbosacral disc herniation with unilateral radiating leg pain in a radicular pattern with or without neurological deficit.

(2) UPPER EXTREMNITY SURGERY. (a) Initial nonsurgical, surgical and chronic management guidelines for upper extremity disorders are found in ss. DWD 81.09 (1) to (16).

(b) *Rotator cuff repair*. Rotator cuff surgery may be performed for the following diagnoses:

1. Rotator cuff syndrome of the shoulder, ICD-9-CM code 726.1, and allied disorders: unspecified disorders of shoulder bursae and tendons, ICD-9-CM code 726.10, calcifying tendinitis of shoulder, ICD-9-CM code 726.11, bicipital tenosynovitis, ICD-9-CM code 726.12, and other specified disorders, ICD-9-CM code 726.19.

2. Tear of rotator cuff, ICD-9-CM code 727.61.

(c) 'Criteria and indications for rorator cuff repair'. In addition to one of the diagnoses in par. (b) both of the following conditions must be satisfied to indicate that surgery is reasonably required:

1. ‘Response to nonsurgical care’. The employee's condition has failed to improve with adequate initial nonsurgical treatment.

2. ‘Clinical findings’: The employee exhibits any of the following:

a. Severe shoulder pain and inability to elevate the shoulder.

b. Weak or absent abduction and tenderness over rotator cuff, or pain relief obtained with an injection of anesthetic for diagnostic or therapeutic trial.

c. Positive findings in arthrogram, MRI, or ultrasound, or positive findings on previous arthroscopy, if performed.

(d) *Acromioplasty diagnosis.* Acromioplasty may be performed for acromial impingement syndrome, ICD-9-CM codes 726.0 to 726.2.

1. ‘Criteria and indications’. In addition to the diagnosis in this paragraph both of the following conditions must be satisfied for acromioplasty:

a.’ Response to nonsurgical care’. The employee's condition has failed to improve after adequate initial nonsurgical care.

b. ‘Clinical findings.’ The employee exhibits pain with active elevation from 90 to 130 degrees and pain at night, and a positive impingement test.

(e) *Repair of acromioclavicular or costoclavicular ligaments.* 1.’Diagnosis’. Surgical repair of acromioclavicular or costoclavicular ligaments may be performed for acromioclavicular separation, ICD-9-CM codes 831.04 to 831.14.

2. ‘Criteria and indications’. In addition to the diagnosis in this paragraph the guidelines of this paragraph must be satisfied for repair of acromioclavicular or costoclavicular ligaments. For the response to nonsurgical care the employee's condition includes any of the following:

a. Failure to improve after at least a one-week trial period in a support brace.

b. Separation cannot be reduced and held in a brace.

c. Grade III separation has occurred.

3. ‘Clinical finding. The employee exhibits localized pain at the acromioclavicular joint and prominent distal clavicle and radiographic evidence of separation at the acromioclavicular joint.

(f) *Excision of distal clavicle diagnosis*. Excision of the distal clavicle may be performed for any of the following conditions specified in subd. 1 to 3:

1. Acromioclavicular separation, ICD-9-CM codes 831.01 to 831.14;

2. Osteoarthrosis of the acromioclavicular joint, ICD-9-CM codes 715.11, 715.21, and 715.31; or

3. Shoulder impingement syndrome.

(g) *Criteria and indications for excision of distal clavicle.* In addition to one of the diagnosis in par. (f) the following conditions must be satisfied for excision of distal clavicle:

1. 'Response to nonsurgical care'. The employee's condition fails to improve with adequate initial nonsurgical care.

2. 'Clinical findings'. The employee exhibits any of the following:

a. Pain at the acromioclavicular joint, with aggravation of pain with motion of shoulder or carrying weight.

b. Confirmation that separation of AC joint is unresolved and prominent distal clavicle, or pain relief obtained with an injection of anesthetic for diagnostic/therapeutic trial.

c. Separation at the acromioclavicular joint with weight-bearing films, or severe degenerative joint disease at the acromioclavicular joint noted on X-rays.

(h) *Repair of shoulder dislocation or subluxation (any procedure)*

1. 'Diagnosis'. Surgical repair of a shoulder dislocation may be performed for the following diagnoses:

a. Recurrent dislocations, ICD-9-CM code 718.31.

b. Recurrent subluxations.

c. Persistent instability following traumatic dislocation.

2. 'Criteria and indications'. In addition to one of the diagnoses in this paragraph the following clinical findings must exist for repair of a shoulder dislocation:

a. The employee exhibits a history of multiple dislocations or subluxations that inhibit activities of daily living.

b. X-ray findings are consistent with multiple dislocations or subluxations.

(i) *Repair of proximal biceps tendon.*

1. ‘Diagnosis’. Surgical repair of a proximal biceps tendon may be performed for proximal rupture of the biceps, ICD-9-CM code 727.62 or 840.8.

2. ‘Criteria and indications’. In addition to the diagnosis in paragraph both of the following conditions must be satisfied for repair of proximal biceps tendon:

a. The procedure may be done alone or in conjunction with another indicated repair of the rotator cuff.

b. ‘Clinical findings’. The employee exhibits complaints of pain that does not resolve with attempt to use arm and palpation of "bulge" in upper aspect of arm.

(j) *Epicondylitis.* Specific guidelines for surgery for epicondylitis are included in s. DWD 81.09 (11).

(k) *Tendinitis*. Specific guidelines for surgery for tendinitis are included in s. DWD 81.09 (12).

(L) *Nerve entrapment syndromes*. Specific guidelines for nerve entrapment syndromes are included in s. DWD 81.09 (13).

(m) *Muscle pain syndromes*. Surgery is not indicated for muscle pain syndromes.

(n) *Traumatic sprains and strains*. Surgery is not indicated for the treatment of traumatic sprains and strains, unless there is clinical evidence of complete tissue disruption. Patients with complete tissue disruption may need immediate surgery.

(3) LOWER EXTREMNITY SURGERY. (a) *Anterior cruciate ligament (ACL) reconstruction*.

1. ‘Diagnoses’. Surgical repair of the anterior cruciate ligament, including arthroscopic repair, may be performed for the following diagnoses:

a. Old disruption of anterior cruciate ligament, ICD-9-CM code 717.83.

b. Sprain of cruciate ligament of knee, ICD-9-CM code 844.2.

2. ‘Criteria and indications’. In addition to one of the diagnoses in this paragraph the conditions in this subd. 2 a to c must be satisfied for anterior cruciate ligament reconstruction. Pain alone is not an indication.

a. The employee gives a history of instability of the knee described as "buckling or giving way" with significant effusion at time of injury, or description of injury indicates a rotary twisting or hyperextension occurred.

b. There are objective clinical findings of positive Lachman's sign, positive pivot shift and/or positive anterior drawer.

c. There are positive diagnostic findings with arthrogram, MRI, or arthroscopy and there is no evidence of severe compartmental arthritis.

(b) *Patella tendon realignment or Maquet procedure.*

1 'Diagnosis'. Patella tendon realignment may be performed for dislocation of patella, open, ICD-9-CM code 836.3, or closed, ICD-9-CM code 836.4, or chronic residuals of dislocation.

2. 'Criteria and indications'. In addition to the diagnosis in this paragraph all of the following conditions must be satisfied for a patella tendon realignment:

a. The employee gives a history of rest pain as well as pain with patellofemoral movement, and recurrent effusion, or recurrent dislocation.

b. There are objective clinical findings of patellar apprehension, synovitis, lateral tracking, or Q angle greater than 15 degrees.

(c) *Knee joint replacement.*

1. 'Diagnoses'. Knee joint replacement may be performed for degeneration of articular cartilage or meniscus of knee, ICD-9-CM codes 717.1 to 717.4.

2. 'Criteria and indications'. In addition to the diagnosis in this paragraph the following conditions must be satisfied for a knee joint replacement:

a. 'Clinical findings'. The employee exhibits limited range of motion, night pain in the joint or pain with weight-bearing, and no significant relief of pain with an adequate course of initial nonsurgical care.

b. 'Diagnostic findings'. There is significant loss or erosion of cartilage to the bone, and positive findings of advanced arthritis and joint destruction with standing films, MRI or arthroscopy.

(d) *Fusion; ankle, tarsal, metatarsal.* 'Diagnoses'. Fusion may be performed for either of the following conditions:

1. Malunion or nonunion of fracture of ankle, tarsal or metatarsal, ICD-9-CM code 733.81 or 733.82.

2. Traumatic arthritis (arthropathy), ICD-9-CM code 716.17.

3.‘Criteria and indications’. In addition to one of the diagnoses in this paragraph the following conditions must be satisfied for an ankle, tarsal or metatarsal fusion. For initial nonsurgical care the employee must have failed to improve with an adequate course of initial nonsurgical care which included any of the following:

a. Immobilization which may include casting, bracing, shoe modification or other orthotics.

b. Anti-inflammatory medications.

4. ‘Clinical findings’ include the following and subd. 5:

a. The employee gives a history of pain which is aggravated by activity and weight-bearing, and relieved by xylocaine injection.

b. There are objective findings on physical examination of malalignment or specific joint line tenderness, and decreased range of motion.

5. ‘Diagnostic findings’. There are medical imaging studies confirming the presence of any of the following:

a. Loss of articular cartilage and joint space narrowing.

b. Bone deformity with hypertrophic spurring and sclerosis.

c. Nonunion or malunion of a fracture.

(e) *Lateral ligament ankle reconstruction*.‘Diagnoses’. Ankle reconstruction surgery involving the lateral ligaments may be performed for the following conditions:

1. Chronic ankle instability, ICD-9-CM code 718.87.

2. Grade III sprain, ICD-9-CM codes 845.0 to 845.09.

3.’ Criteria and indications’. In addition to one of the diagnoses in this paragraph the following conditions must be satisfied for a lateral ligament ankle reconstruction. For initial nonsurgical care the employee must have received an adequate course of initial nonsurgical care including one of the following:

a. Immobilization with support, cast, or ankle brace.

b. a physical rehabilitation program that follows immobilization with support, cast or ankle brace.

4. ‘Clinical findings’ include any of the following:

a. The employee gives a history of ankle instability and swelling.

b. There is a positive anterior drawer sign on examination.

c. There are positive stress X-rays identifying motion at ankle or subtalar joint with at least a 15 degree lateral opening at the ankle joint, or demonstrable subtalar movement, and negative to minimal arthritic joint changes on X-ray, or ligamentous injury is shown on MRI scan.

5. *Prosthetic ligaments*. Prosthetic ligaments are not indicated.

DWD 81.13 Chronic management. (1) SCOPE. This section applies to chronic management of all types of physical injuries, even if the injury is not specifically governed by ss. DWD 81.06 to 81.12. If a patient continues with symptoms and physical findings after all appropriate initial nonsurgical and surgical treatment has been rendered, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. The purpose of chronic management is twofold: the patient should be made independent of health care providers in the ongoing care of a chronic condition; and the patient should be returned to the highest functional status reasonably possible.

(a) Personality or psychological evaluation may be indicated for patients who are candidates for chronic management. The treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, the health care provider performing the evaluation must consider all of the following:

1. Is symptom magnification occurring?

2. Does the patient exhibit an emotional reaction to the injury, such as depression, fear or anger, which is interfering with recovery?

3. Are there other personality factors or disorders which are interfering with recovery?

4. Is the patient chemically dependent?

5. Are there any interpersonal conflicts interfering with recovery?

6. Does the patient have a chronic pain syndrome or psychogenic pain?

7. In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?

(b) Any of the chronic management modalities of sub. (2) may be used singly or in combination as part of a program of chronic management.

(c) No further passive treatment modalities or therapeutic injections are indicated, except as otherwise provided in s. DWD 81.06 (3) (b), s. DWD 81.07 (3) (b), s. DWD 81.08 (3) (b) and s. DWD 81.09 (3) (b).

(d) No further diagnostic evaluation is indicated unless there is the development of symptoms or physical findings which would in themselves warrant diagnostic evaluation.

(e) A program of chronic management must include appropriate means by which use of scheduled medications can be discontinued or severely limited.

(2) CHRONIC MANAGEMENT MODALITIES. (a) *Home-based exercise programs.* Home-based exercise programs consist of aerobic conditioning, stretching and flexibility exercises, and strengthening exercises done by the patient on a regular basis at home without the need for supervision or attendance by a health care provider. Maximum effectiveness may require the use of certain durable medical equipment that may be prescribed within any applicable treatment guidelines in ss. DWD 81.06 to 81.10.

1.' Indications'. Exercise is necessary on a long-term basis to maintain function.

2.'Guidelines'. The patient should receive specific instruction and training in the exercise program. Repetitions, durations and frequencies of exercises must be specified.

3. Treatment period is one to three visits for instruction and monitoring.

(b) *Health clubs.*

1. 'Indications'. The patient is deconditioned and requires a structured environment to perform prescribed exercises. The health care provider must document the reasons why reconditioning cannot be accomplished with a home-based program of exercise.

2. 'Guidelines'. The program must have specific prescribed exercises stated in objective terms, for example "30 minutes riding stationary bicycle three times per week." There must be a specific set of prescribed activities and a specific timetable of progression in those activities, designed so that the goals can be achieved in the prescribed time. There must be a prescribed frequency of attendance and the patient must maintain adequate documentation of attendance. There must be a prescribed duration of attendance.

3. Treatment period is 13 weeks. Additional periods of treatment at a health club are not indicated unless there is documentation of attendance and progression in activities during the preceding period of treatment. If the employer has an appropriate exercise facility on its premises the insurer may mandate use of that facility instead of providing a health club membership.

(c) *Computerized exercise programs*. Computerized exercise programs utilize computer controlled exercise equipment that allows for the isolation of specific muscle groups and the performance of graded exercise designed to increase strength, tone, flexibility and range of motion. In combination with computerized range of motion or strength measuring tests, these programs allow for quantitative measurement of effort and progress.

1. 'Indications'. The patient is deconditioned and requires a structured environment to accomplish rehabilitation goals. The health care provider must document the reasons why reconditioning cannot be accomplished with a home-based program of exercise.

2.'Guidelines'. The program must have specific goals stated in objective terms, for example "improve strength of back extensors 50 percent." There must be a specific set of prescribed activities and a specific timetable of progression in those activities, designed so that the goals can be achieved in the prescribed time. There must be a prescribed frequency and duration of attendance.

3. Treatment period is six weeks. Additional periods of treatment are not indicated unless there is documentation of attendance and progression in activities during the preceding period of treatment.

(d) *Work conditioning and work hardening programs*. Work conditioning and work hardening programs are intensive, highly structured, job oriented, individualized treatment plans based on an assessment of the patient's work setting or job demands, and designed to maximize the patient's return to work. These programs must include real or simulated work activities. Work conditioning is designed to restore an individual's neuromusculoskeletal strength, endurance, movement, flexibility and motor control, and cardiopulmonary function. Work conditioning uses physical conditioning and functional activities related to the individual's work. Services may be provided by one discipline of health care provider. Work hardening is designed to restore an individual's physical, behavioral and vocational functions within an interdisciplinary model. Work hardening addresses the issues of productivity, safety, physical tolerances

and work behaviors. An interdisciplinary team includes professionals qualified to evaluate and treat behavioral, vocational, physical and functional needs of the individual.

1. 'Indications'. The patient is disabled from usual work and requires reconditioning for specific job tasks or activities and the reconditioning cannot be done on the job. The health care provider must document the reasons why work hardening cannot be accomplished through a structured return to work program. Work conditioning is indicated where only physical and functional needs are identified. Work hardening is indicated where, in addition to physical and functional needs, behavioral and vocational needs are also identified that are not otherwise being addressed.

2. 'Guidelines'. The program must have specific goals stated in terms of work activities, for example "able to type for 30 minutes." There must be an individualized program of activities and the activities must be chosen to simulate required work activities or to enable the patient to participate in simulated work activities. There must be a specific timetable of progression in those activities, designed so that the goals can be achieved in the prescribed time. There must be a set frequency and hours of attendance and the program must maintain adequate documentation of attendance. There must be a set duration of attendance. Activity restrictions must be identified at completion of the program.

3. Treatment period is six weeks. Additional periods of treatment at a work hardening program or work conditioning program are not indicated unless there is documentation of attendance and progression in activities during the preceding period of treatment or unless there has been a change in the patient's targeted return to work job which necessitates a redesign of the program.

(e) *Chronic pain management programs*. Chronic pain management programs consist of multidisciplinary teams who provide coordinated, goal-oriented services to reduce pain disability, improve functional status, promote return to work and decrease dependence on the health system of persons with chronic pain syndrome. Pain management programs must provide physical rehabilitation, education on pain, relaxation training, psychosocial counseling, medical evaluation and, if indicated, chemical dependency evaluation. The program of treatment must be individualized and based on an organized evaluative process for screening and selecting patients. Treatment may be provided in an inpatient setting, outpatient setting, or both as appropriate.

1. 'Indications'. The patient is diagnosed as having a chronic pain syndrome.

2. ‘Guidelines’. An admission evaluation must be performed by a practitioner. The evaluation must confirm the diagnosis of chronic pain syndrome and a willingness and ability of the patient to benefit from a pain management program. There must be a specific set of prescribed activities and treatments, and a specific timetable of progression in those activities. There must be a set frequency and hours of attendance and the program must maintain adequate documentation of attendance. There must be a set duration of attendance.

3. Treatment period is for initial treatment, a maximum of 20 eight-hour days, though fewer or shorter days can be used, and a maximum duration of four weeks no matter how many or how long the days prescribed. For aftercare, a maximum of 12 sessions is allowed. Only one completed pain management program is indicated for an injury.

(f) *Individual or group psychological or psychiatric counseling*.

1. “Indications’. A personality or psychosocial evaluation has revealed one or more of the problems listed in sub. (1) (a) which interfere with recovery from the physical injury, but the patient does not need or is not a candidate for a pain management program.

2. ‘Guidelines’. There must be a specific set of goals based on the initial personality or psychosocial evaluation and a timetable for achieving those goals within the prescribed number of treatment or therapy sessions. There must be a prescribed frequency of attendance and the treating health care provider must maintain adequate documentation of attendance. There must be a prescribed duration of treatment.

3. Treatment period is a maximum of 12 sessions. Only one completed program of individual or group psychological or psychiatric counseling is indicated for an injury.

DWD 81.14 Health care provider advisory committee. (1) The department shall establish a health care services provider committee to advise the department and the council on worker’s compensation on modification of the treatment standards under this section. The administrator of the worker’s compensation division shall serve as chairperson. The committee shall consist of 14 members including six medical doctors of different specialties, two chiropractors, two hospital representatives, one registered nurse, one physical therapist and two at large members all of whom are licensed in and practicing in Wisconsin and provide treatment under s. 102.42, Stats. The appointments to the committee

shall be made from a consensus list of 24 names submitted by the Wisconsin Medical Society, Wisconsin Chiropractic Association and the Wisconsin Hospital Association, except for the two members who shall be selected by the department.

(2) In modifying the guidelines the committee shall consider the following:

(a). Clarifying the description of the guidelines under this section.

(b) Updating the guidelines to include new modalities of treatment, procedures and treatment options for classes of injuries included in the initial guidelines.

(c) Expanding the guidelines to cover new types and classes of injuries.

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